## FORMS

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<td>Sample Remittance Advice (four pages)</td>
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<td>Transplant Prior Authorization Request Form &amp; Instructions (two pages)</td>
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<td>Hereditary Breast and Ovarian Cancer (HBOC)</td>
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<td>SCDHHS Prior Authorization Form for Fetal DNA Blood Test</td>
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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.

<table>
<thead>
<tr>
<th>SUSPECTED INDIVIDUAL OR INDIVIDUALS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI or MEDICAID PROVIDER ID: (if applicable)</td>
</tr>
<tr>
<td>ADDRESS OF SUSPECT:</td>
</tr>
<tr>
<td>DATE OF INCIDENT:</td>
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</table>

COMPLAINT:

<table>
<thead>
<tr>
<th>NAME OF PERSON REPORTING: (Please print)</th>
<th>SIGNATURE OF PERSON REPORTING:</th>
<th>DATE OF REPORT</th>
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<tbody>
<tr>
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<td>TELEPHONE NUMBER OF PERSON REPORTING:</td>
<td></td>
</tr>
<tr>
<td>SIGNATURE: (SCDHHS Representative Receiving Report)</td>
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SCDHHS Form 126 (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 #**

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:**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Medicaid I.D.# (10 digits)</th>
<th>Date(s) of Service</th>
<th>Amount of Medicaid Payment</th>
<th>Amount of Refund</th>
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</tr>
</tbody>
</table>

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

DHHS Form 205 (01/08)
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

DHHS 931 – Updated February 2018
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.
ATTACH A COPY OF THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014
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

SCDHHS (Revised 06/01/17)
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): _____________________________ Medicaid Beneficiary ID: _____________________________
Date of Birth: _____________________________

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 □ Physician 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: _____________________________
Section 5: Desired Outcome

Request submitted by:

Print Name: __________________________________________

Signature: ___________________________________________ Date: ________
Sample Remittance Advice (page 1)

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

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
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<tr>
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<th>CLAIM</th>
<th>SERVICE RENDERED</th>
<th>AMOUNT</th>
<th>TITLE 19</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
<th>M</th>
<th>TLE. 18</th>
<th>COPAY</th>
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<td>OWN REF.</td>
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<td>DATE(S)</td>
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<td>PAYMENT</td>
<td>ID.</td>
<td>F</td>
<td>M</td>
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<td>AMT</td>
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<tr>
<td>NUMBERS</td>
<td>NUMBERS</td>
<td>PY IND.</td>
<td>MMDDYY</td>
<td>PROC.</td>
<td>MEDICAID</td>
<td>NUMBER</td>
<td>I I LAST NAME</td>
<td>O</td>
<td>D</td>
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<td>R</td>
<td>071913</td>
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| TOTALS | 3 | 310.00 | $6.72 |

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL". PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.
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.

<table>
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<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
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<th>PROV. OWN REF.</th>
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<th>DATE(S)</th>
<th>AMOUNT</th>
<th>TITLE 19</th>
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<td>M CLARK</td>
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<td>0.00</td>
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</table>

$286.46 |

FOR AN EXPLANATION OF THE STATUS CODES: PROVIDER NAME AND ADDRESS

ERROR CODES LISTED ON THIS CERT. PG TOT | MEDICAID PG TOT | P = PAYMENT MADE | ABC HEALTH PROVIDER |

FORM REFER TO: "MEDICAID" | $0.00 | $286.46 | R = REJECTED | |

PROVIDER MANUAL". CERTIFIED AMT | MEDICAID TOTAL | S = IN PROCESS | PO BOX 000000 |

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER | 0.00 |

SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL. CHECK TOTAL | CHECK NUMBER |
### Table: Sample Remittance Advice (page 3)

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

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>CLAIM</th>
<th>ADJUSTMENTS</th>
<th>PAYMENT DATE</th>
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**PROVIDERS**

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<th>PY</th>
<th>DATE(S)</th>
<th>MEDICAID</th>
<th>BILLED</th>
<th>andersen</th>
<th>AMOUNT</th>
<th>TITLE 19</th>
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<th>ORG</th>
<th>CHECK</th>
<th>REFERENCE</th>
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<td>CLARK</td>
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<td><strong>TOTALS</strong></td>
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**Debit Balance**

- Prior to this: $243.71
- To be refunded: 0.00

**Recipient**

- Last Name: CLARK
- Address: ABC HEALTH PROVIDER

**Claim Level**

- Original CCN: 1328300224813300A
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.

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
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<tr>
<td>AB11110000</td>
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<td>02/28/2014</td>
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<table>
<thead>
<tr>
<th>PROVIDERS</th>
<th>CLAIM REFERENCE</th>
<th>SERVICE DATE(S)</th>
<th>PROC / DRUG CODE</th>
<th>RECIPIENT ID.</th>
<th>F M</th>
<th>RECIPIENT NAME</th>
<th>ORIG. CHECK</th>
<th>PAYMENT ACTION</th>
<th>CREDIT AMOUNT</th>
<th>DEBIT / CREDIT AMOUNT</th>
<th>MEDICAID TOTAL</th>
<th>CERTIFIED AMT</th>
<th>MEDICAID REIMBURSED IN THE FUTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPL 2</td>
<td>1404900004000100U</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DEBIT</td>
<td>-2389.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TPL 4</td>
<td>14055000076000400U</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DEBIT</td>
<td>-1949.90</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TPL 5</td>
<td>1404900004000100U</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DEBIT</td>
<td>-477.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TPL 6</td>
<td>14055000076000400U</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CREDIT</td>
<td>477.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 00000
FLORENCE, SC 00000

PAGE TOTAL: 4338.95
0.00
## HEALy MOTHERS, HEAly FUTURES
Maternity Health Education Checklist

**PATIENT'S NAME:**

**INSTRUCTIONS:** This format provides for written documentation of providing health education to Medicaid maternity patients and suggests the range of topics that generally would be provided.

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>COMPLETED</th>
<th>DATE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OFFICE SERVICES AND ROUTINES: Information about hours, appointments, lab tests, and other general procedures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GENERAL INSTRUCTION ABOUT PREGNANCY: such as hygiene, exercise, sexuality, medication, and importance of prenatal care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FETAL GROWTH AND DEVELOPMENT: how the baby develops month by month and physical and psychological changes experienced by the mother; including comfort measures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NUTRITION: including routine prenatal diet instruction. (Be sure to make referral to WIC PROGRAM)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EXPLANATION OF EDC: Understanding the due date.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DANGER SIGNS OF PREGNANCY: recognizing the warning signs and significance and risk of each; including specific instructions on what to do, who to contact and where to go in an emergency.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RISKY BEHAVIORS: smoking, alcohol, substance use and abuse the risks, consequences to baby and methods for avoiding risks. NOTE: Possible referral for smoking cessation or substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROCESS OF LABOR AND DELIVERY: discussion of physical process of labor and delivery, including psychological changes experienced.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>METHODS OF ANESTHESIA: Information on types of anesthesia with discussion of benefits, risks and alternatives; also pain medication.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CESAREAN SECTION: discussion of what it is and what are the usual indications including risks and benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RELAXATION AND BREATHING EXERCISES: preparation for labor including demonstration and practice of exercises and breathing techniques</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| BREASTFEEDING: factors to consider in decision making and preparation of the breasts  
Note: Possible referral to La Leche or Breastfeeding Support |           |         |

(Continued on Reverse)
**MATERNITY EDUCATION CHECKLIST (Continued)**

<table>
<thead>
<tr>
<th>PREPARATION OF OTHER FAMILY MEMBERS: sibling preparation and needs of other family members before and after birth of child; father support and involvement.</th>
<th>DATE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DELIVERY ARRANGEMENTS: Hospital tours, expectations and procedures during delivery and hospital stay.</td>
<td></td>
</tr>
<tr>
<td>POSTPARTUM CARE: Immediate postpartum needs and six weeks check-up and physical care at home, including psychological needs and adjustments.</td>
<td></td>
</tr>
<tr>
<td>FAMILY PLANNING: Importance of family planning; risks of short interconceptional period and discussion of all methods.</td>
<td></td>
</tr>
<tr>
<td>INFANT CARE AND PARENT EDUCATION: Routine infant care needs including preventive care, safety, expectations for infant development and provision for infant health care provider. Note: possible EPSDT referral.</td>
<td></td>
</tr>
<tr>
<td>OTHER: Note special areas covered</td>
<td></td>
</tr>
</tbody>
</table>

**REFERRAL:**

| WIC PROGRAM: | Date:   |
|              |         |
| HRCP (if applicable) | Date:   |
| High Risk Channeling Project | Date:   |
| OTHER | Date:   |

**SIGNATURE:_____________________________**

Attending Physician
### Alcohol and Drug Medical Assessment

<table>
<thead>
<tr>
<th>Patient's Name (Last, First, MI) and I.D. #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Client #</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Physician's Name and Address</td>
</tr>
</tbody>
</table>

1. Brief medical history to include hospital admissions, surgeries, allergies, present medications, information (where appropriate) about shared needles, sexual activity/orientation and history of hepatitis and liver disease.

2. History of patient/family involvement with alcohol/drugs.

3. Assessment of patient nutritional status.
4. Physical examination to include, but not be limited to, vital signs, inspection of ears, nose, mouth, teeth and gums. Also, inspection of skin for recent and/or old needle marks/tracking, abscesses or scarring from healed abscesses.

5. General assessment of patient cardiovascular system, respiratory system, gastro-intestinal system and neurological status.

6. Screening for anemia (hematocrit or hemoglobin may be used when physician has machinery available in office).

7. It is ordered that ______________________________ receive alcohol/drug rehabilitative services.

Physician's Signature and Date
# Pediatric Sub-Specialists Certification Form

## Section I: Physician Demographic Information

*(Please Print)*

<table>
<thead>
<tr>
<th>Name (First, Middle, Last):</th>
<th>NPI#:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Location Address:</td>
<td>Suite/Unit #:</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>E-mail Address:</td>
<td>Fax Number:</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>Mailing Address (if different from physical location address):</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
</tbody>
</table>

## Section II: Attestation Statement

Beginning February 1, 2006, the monies appropriated for pediatric physician sub-specialists shall only be available to a physician who:

- **A** in his/her medical practice, has at least 85% of their patients who are children 18 years or younger and
- **B** practices in one of the following sub-specialties or other pediatric sub-specialty area as may be determined by the Department of Health and Human Services:

### Pediatric Sub-Specialties (Check All That Apply)

- [ ] Adolescent Medicine
- [ ] Emergency Medicine
- [ ] Nephrology
- [ ] Pulmonology
- [ ] Allergy
- [ ] Endocrinology
- [ ] Neurology
- [ ] Radiology
- [ ] Cardiology
- [ ] Gastroenterology/Nutrition
- [ ] Neurological Surgery
- [ ] Rheumatology
- [ ] Cardiothoracic Surgery
- [ ] Genetics
- [ ] Ophthalmology
- [ ] Surgery
- [ ] Child Abuse Pediatrics
- [ ] Hematology/Oncology
- [ ] Orthopedic Surgery
- [ ] Urology
- [ ] Critical Care
- [ ] Infectious Disease
- [ ] Otolaryngology
- [ ] Psychiatry
- [ ] Developmental-Behavioral Pediatrics
- [ ] Neonatology
- [ ] Psychology

## Certification

I hereby certify that:

1. I am a physician member in good standing on the medical staff of a hospital.
2. I am qualified in and practice in the pediatric specialty noted in Section II above.
3. At least 85% of my total practice, including after-hours patients, is dedicated to children age 18 years and under.

### Patient Heading

<table>
<thead>
<tr>
<th>Patient Heading</th>
<th>As a Group</th>
<th>As an Individual</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients seen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Medicaid patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of patients 18 and under</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of patients with Medicaid 18 and under</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Attestation/Assurances and Signature

I am providing this attestation certificate to the South Carolina Department of Health and Human Services with the request that I be included on the list of pediatric specialists eligible for enhanced reimbursement for selected services provided to children enrolled in the South Carolina Medicaid program. I hereby certify, under penalty of perjury, that the information provided on this certificate is correct as of the date of this certificate.

Physician Signature: __________ Date: __________

## Contact Person Information

<table>
<thead>
<tr>
<th>Contact Person Name (please print):</th>
<th>Contact Email Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Telephone Number:</td>
<td>Contact Fax Number:</td>
</tr>
</tbody>
</table>

Please **FAX** or **MAIL** completed/signed form to:

**Medicaid Provider Enrollment**

**FAX:** 803-870-9022

**MAIL:** POB 8809, Columbia, SC 29202-8809

*DHHS Pediatric Sub-Specialists Certification Form*

*Revised: 06/15 - Replaces: 10/14*
ABORTION STATEMENT

This certification meets FFP requirements and must include all of the aforementioned criteria.

Patient's Name: ______________________________________________________

Patient's Medicaid ID#: ______________________________________________

Patient's Address: ____________________________________________________

Physician Certification Statement

I, __________________________________________ certify that it was necessary to terminate the pregnancy of ___________________________ for the following reason:

a. ( ) Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition: ____________________________________________

b. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.

   c. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

      _______________________________ ________________________________
      Physician's Signature Date

The patient's certification statement is only required in cases of rape or incest.

Patient's Certification Statement

I, __________________________________________ certify that my pregnancy was the result of an act of rape or incest.

(Patient's Name)

      _______________________________ ________________________________
      Patient's Signature Date

Both the completed Abortion Statement and appropriate medical records must be submitted with the claim form.
CONSENT FOR STERILIZATION

**CONSENT TO STERILIZATION**

I have asked for and received information about sterilization from __________________________. When I first asked __________________________ for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as __________________________. The discomfarts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: __________________________.

I, __________________________, hereby consent of my own free will to be sterilized by __________________________.

__________________________
Doctor or Clinic

by a method called __________________________. My __________________________ consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

__________________________
Signature of Individual
Date

**STATEMENT OF PERSON OBTAINING CONSENT**

Before __________________________ signed the consent form, I explained to him/her the nature of sterilization operation __________________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

__________________________
Signature of Person Obtaining Consent
Date

**PHYSICIAN’S STATEMENT**

Shortly before I performed a sterilization operation upon __________________________ on __________________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual’s signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual’s signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual’s signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery
- Individual’s expected date of delivery: __________________________
- Emergency abdominal surgery (describe circumstances):

__________________________
Physician’s Signature
Date

**INTERPRETER’S STATEMENT**

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

__________________________
Interpreter’s Signature
Date

HHS-687 (07/2025)
SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY

THIS COMPLETED FORM AND A SIGNED “CONSENT FOR STERILIZATION” FORM MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.

PATIENT
NAME ___________________________________ MEDICAID # __________________
LAST   FIRST   MI
BIRTHDATE __________________ GRAVITY _______________ PARITY ________________
MONTH/DAY/YEAR

PROCEDURE CODE: ________________________  DX CODE:____________________

HOSPITAL ________________________________
NAME ____________________ NPI (IF AVAILABLE)

PLANNED ADMISSION DATE _______________ PLANNED SURGERY DATE ________________

TYPE OF HYSTERECTOMY PLANNED__________________________________________________

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

HCT ____   HGB ____   CHECK ONE: PREMENOPAUSAL _____  POSTMENOPAUSAL _____

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:
___________________________________________________________________________________
___________________________________________________________________________________

PRIOR GYN SURGERY/DIAGNOSTIC PROCEDURES (INCLUDE COPIES OF ALL REPORTS):
___________________________________________________________________________________
___________________________________________________________________________________

OFFICE NOTES AND ALL SUPPORTING DOCUMENTATION (e.g., ULTRASOUND, OPERATIVE AND PATH REPORTS, ETC.) ARE REQUIRED FOR APPROVAL AND SHOULD BE ATTACHED TO THIS FORM.

ATTENDING PHYSICIAN’S NAME ____________________________________________ NPI
LAST   FIRST   MI
ADDRESS ________________________________________________________________________________

CONTACT PERSON ______________________________ TELEPHONE (____) ________________
FAX (____) __________________

SIGNATURE __________________________________ DATE __________________________
ATTENDING PHYSICIAN

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

Revised: 06/01/12
SOUTH CAROLINA MEDICAID PROGRAM
REQUEST FOR PRIOR APPROVAL REVIEW BY KEPRO

PATIENT NAME ______________________________________________________________
LAST   FIRST     MI

BIRTHDATE ____________________   *MEDICAID# ____________________________
MONTH/DAY/YEAR

PROCEDURE ____________________________________ CODE _______________________

DX CODE:_______________________________________

FACILITY _______________________________________    ___________________________
NAME W                                NPI #

PLANNED SURGERY DATE _______________________________________

*TO AVOID THE RISK OF NON–PAYMENT, PROVIDERS SHOULD CHECK ELIGIBILITY
OF RECIPIENT PRIOR TO REQUEST FOR PRIOR APPROVAL REVIEW. IF THE
RECIPIENT IS MANAGED CARE, PRIOR APPROVAL MUST BE OBTAINED THROUGH
THE MANAGED CARE PROVIDER.

PHYSICIAN’S NAME __________________________________________________________
LAST   FIRST   MI

ADDRESS ____________________________________________________________________

_________________________________ NPI: _____________

CONTACT PERSON _________________________ TELEPHONE (_____) _______________
DATE ____________________   FAX NUMBER (_____) ______________

• OFFICE NOTES DOCUMENTING THE REQUESTED INFORMATION MUST BE ATTACHED
• ALL PERTINENT DOCUMENTATION FOR THE PROCEDURE SHOULD BE MAILED TOGETHER
• PROVIDERS WILL BE NOTIFIED OF DETERMINATION VIA MAIL

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE

Revised: 06/01/12
Section I: Demographic Information
Please Print:

Supervising Clinician Name:
Address:
Telephone:
National Provider Identifier Number (NPI)
Fax:
Email:

Section II: Allied Professional Update Form
The Licensed Master Social Workers (LMSW) listed below are under my supervision and services rendered and billed to South Carolina Medicaid will be in compliance with the guidelines as provided in the South Carolina Medicaid Physicians and other Medical Professions Manual

LMSW Name (as it appears on their license):
License Number & Expiration Date:

LMSW Name (as it appears on their license):
License Number & Expiration Date:

LMSW Name (as it appears on their license):
License Number & Expiration Date:

LMSW Name (as it appears on their license):
License Number & Expiration Date:

Should there be changes to this list, the professional’s qualifications, and/or licensure, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply may result in the recoupment for services rendered. All allied professionals must be listed each time this form is submitted and a maximum of three allied professionals are permitted.

I hereby certify, that the information provided in the certificate is correct as of the date of this certificate.

___________________________
Physician Signature

___________________________
Date

Revised 08/2013
Please ensure all items on the checklist are included prior to submitting the packet.

*Incomplete requests will not be processed. Please allow up to two weeks for processing.*

- Valid point of contact information is provided for referring and out-of-state providers
- Completed and signed Form A – To be completed by South Carolina referring provider
- Completed and signed Form B – To be completed by the out-of-state (OOS) provider. This form indicates that the provider has been contacted and has confirmed, in writing, that they are enrolled or have begun to enroll in the South Carolina Healthy Connections Medicaid program and will accept Healthy Connections Medicaid reimbursement as payment-in-full
- One year of medical records/clinical notes that support the decision to refer out-of-state
- If Medicaid is not the primary insurance, prior authorization (PA)/denial from primary insurance is attached
  - If no PA is required from primary insurance, please advise: ____________________________
FORM A
To be completed by the South Carolina referring provider.
All fields are required and failure to complete each section will cause a delay in processing.

<table>
<thead>
<tr>
<th>Member Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Will member require meals, lodging and transportation (ancillary) assistance?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Services are (Select one):</th>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
</table>

Ancillary assistance is provided for the member and one (1) escort for approved services, where applicable.

Adequate advanced notice and prior approval from SCDDHHS are mandatory prior to the broker arranging travel.

Hotel accommodations are for outpatient services only. Retroactive reimbursement will not be approved.

<table>
<thead>
<tr>
<th>Referring Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Name</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition requiring treatment</td>
</tr>
</tbody>
</table>

**REQUIRED**
Brief explanation of medical need to receive services outside of the South Carolina Medicaid Service Area (SCMSA).
The SCMSA includes all of South Carolina and regions of North Carolina and Georgia within 25 miles of the South Carolina border.

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Diagnosis Code(s)</th>
<th>HCPCS/CPT</th>
<th>Procedure Code(s)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient is being referred to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of service (if no appointment is scheduled, enter “tentative”)</th>
<th>Date of return (refers to length of stay for the service)</th>
</tr>
</thead>
</table>

- I certify communication has been established with the out-of-state provider.
- I certify the aforementioned services are not available or provided within the South Carolina Medicaid Service Area (SCMSA).

_________________________________________  __________________
Signature of Referring Provider                Date
FORM B
To be completed by the out-of-state rendering provider. Separate form to be completed for each individual provider rendering/billing for services.

All fields are required.

<table>
<thead>
<tr>
<th>Provider Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Individual</td>
<td>☐ Facility</td>
</tr>
<tr>
<td>Provider Name</td>
<td>NPI</td>
</tr>
<tr>
<td>Contact Phone Number</td>
<td>Fax Number</td>
</tr>
<tr>
<td>Member Name</td>
<td>Member Date of Birth</td>
</tr>
</tbody>
</table>

By signing below, the out-of-state facility and physician(s) certifies the following:

- Facility and physician(s) are enrolled or have initiated enrollment with South Carolina Healthy Connections Medicaid (if enrolling, please provide the 15-digit alpha-numeric Communication ID or a screenshot of the in-process application)
- Accepting South Carolina Healthy Connections Medicaid reimbursement as payment-in-full

____________________________________  ______________________________
Authorized Signature of Out-of-State Provider  Date

____________________________________
Printed Name of Authorized Representative

Please Note: If the out-of-state provider does not sign or indicates a reason for refusal, the referral request will not be processed or reviewed.

For information concerning enrollment and claims submission for out-of-state hospital providers, please see “Out-of-State Hospitals” in the Hospital Services Provider Manual. The most current version of the provider manual is maintained on the SCDHHS website at www.scdhhs.gov.

Services for members enrolled in managed care organizations (MCOs) are to be requested through the MCO using the entity’s prior authorization process.

For a complete copy of the out-of-state services policy, please refer to the Physicians Services Provider Manual. The most current version of the provider manual is maintained on the SCDHHS website at www.scdhhs.gov. If you have additional questions, please contact the Provider Service Center at (888) 289-0709, submit an inquiry at http://www.scdhhs.gov/contact-us, or contact your MCO representative at (803) 898-4614.
TRANSPLANT PRIOR AUTHORIZATION REQUEST FORM INSTRUCTIONS

The South Carolina Department of Health and Human Services (SCDHHS) may use guidelines that include clinical standards, protocols, or criteria regarding the treatment of specific conditions in determining whether to provide prior authorization.

General Information

- All transplant prior authorization requests require at least 10 days advance notice.
- Ensure most recent version of the Transplant Prior Authorization Request form is submitted.
- The referring South Carolina (SC) Medicaid provider must complete the form.
- All fields on the form must be completed.
- Providers seeking reimbursement for services must be credentialed with SC Medicaid.
- Incomplete prior authorization requests are administratively denied. Requests are considered only when completed and received before the service is provided.
- Include supporting clinical documentation (e.g., clinical notes, diagnostic studies, lab results)
- Authorization approval is not an authorization for payment. Payments are made based on the beneficiary’s eligibility and benefits on the day of service.
- If the transplant service is available in state and this case is being referred outside of the South Carolina Medical Service Area (SCMSA), you must indicate why.

Requests for prior authorizations may be submitted to Kepro using one of the following methods.

Kepro Customer Service: 1-855-326-5219
Kepro Fax #: 1-855-300-0082
For Provider Issues email: atrezzoissues@Kepro.com
Transplant Prior Authorization Request Form

Omissions, generalities, and illegibility will result in the form being returned for completion or clarification. Please note that the approval of a transplant evaluation does not guarantee the approval of the actual transplant.

**BENEFICIARY INFORMATION**

| NAME OF BENEFICIARY: _______________________ | SC MEDICAID #: ___________________ | DATE OF BIRTH: ________________ |
| NAME OF GUARDIAN (if applicable): ____________________ | CONTACT NUMBER: ____________________ |

**PROVIDER INFORMATION**

| NAME OF REFERRING PHYSICIAN: ______________________ | NPI: ___________________ | SC MEDICAID #: ___________________ |
| TYPE OF TRANSPLANT: ______________________ | TYPE OF ORGAN BEING RECEIVED: Living ______ Cadaveric ______ |
| EXPECTED DATE OF SERVICE: ______________________ |

| NAME OF PHYSICIAN(S): ______________________ | NAME OF FACILITY: ______________________ |
| FACILITY NPI: ___________________ | FACILITY SC MEDICAID #: ___________________ |
| FACILITY ADDRESS: ______________________ | CITY: ______ STATE: ______ ZIP: ______ |
| NAME OF CONTACT PERSON/COORDINATOR: ______________________ |
| TELEPHONE: ______________________ | FAX: ______________________ |

**DIAGNOSIS/PROCEDURE CODES and DESCRIPTIONS**

<table>
<thead>
<tr>
<th>ICD-10 DIAGNOSIS CODE(S)</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>______________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROCEDURE CODE(S)</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>______________________</td>
</tr>
</tbody>
</table>

**REQUIRED DOCUMENTATION**

Letter of Medical Necessity for the transplant, including the following:
- Summary of course of illness, current medications, smoking, alcohol, and drug abuse history must be six months free from use.
- Medical records, including physical exam, medical history, family history and laboratory assessments including serologies
- Letter to support the need to have the transplant performed outside of the South Carolina Medical Service Area (SCMSA) - if applicable.

I certify that the above information is correct, and that contact has been made with the Rendering Facility/Physician. I also certify that if the request is to a provider and/or facility outside of the SCMSA, that the service is not available and cannot be provided within the SCMSA.

_________________________________________________________  
SIGNATURE OF REFERRING PHYSICIAN  DATE
# South Carolina
Department of Health and Human Services
Mental Health Form

FILL OUT COMPLETELY TO AVOID DELAYS

<table>
<thead>
<tr>
<th>Beneficiary Information</th>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary’s Name:</td>
<td>Individual NPI:</td>
</tr>
<tr>
<td>Medicaid ID #:</td>
<td>Organization NPI:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Service Location Address:</td>
</tr>
<tr>
<td></td>
<td>City &amp; State:</td>
</tr>
</tbody>
</table>

## DSM-IV TR Diagnosis

<table>
<thead>
<tr>
<th>Axis I</th>
<th>Axis II</th>
<th>Axis III</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date first seen: ____________ Date of last service: ____________ # of additional visits requested: ____________

**Current Clinical Information:** (Circle each. Scale 0=None, 1=Mild, 2=Moderate, 3=Severe, 4=Extreme)

<table>
<thead>
<tr>
<th>Alcohol/Substance Use</th>
<th>Depressions</th>
<th>Relationship Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anxiety/Panic</th>
<th>Impulsivity</th>
<th>Sleep Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appetite Disturbance</th>
<th>Job/School Problems</th>
<th>Sleep Disturbance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attention/Concentration</th>
<th>Mania</th>
<th>Weight Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deficit in ADls</th>
<th>Medical Illness</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Delusions</th>
<th>Memory</th>
<th>Current Stressors</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

## Services

- 90833
- 90836
- 90838
- 90846
- 90847
- 96101
- 90853
- 90832
- 90837
- 96102

## Current Medications

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Compliance: >90%  50-90%  <50%

Reasons for Noncompliance:

---

Physician Name: __________________________ Phone: ______________________ Fax: ______________________

Physician Signature: __________________________ Date: ______________________

Clinical documentation must be submitted with this request and submitted to the QIO using one of the following methods:

Disclaimer: Authorization indicates that SCDHHS determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary’s eligibility and benefit limitations at the time services are rendered. The Physician Assistant is not authorized to sign this form.
SOUTH CAROLINA MEDICAID PROGRAM
PSYCHIATRIC PRIOR AUTHORIZATION

*TO AVOID THE RISK OF NON-PAYMENT, PROVIDERS SHOULD CHECK ELIGIBILITY OF RECIPIENT PRIOR TO REQUEST FOR PRIOR APPROVAL REVIEW. IF THE RECIPIENT IS MANAGED CARE, PRIOR APPROVAL MUST BE OBTAINED THROUGH THE MANAGED CARE PROVIDER.

DATE: ______________________

PATIENT NAME: ________________________________ MEDICAID #: ___________________________

Last First Mi

BIRTH DATE: ________________________________ INPATIENT ______ OUTPATIENT ______

MONTH/DAY/YEAR

PRIMARY DX: (CIRCLE ONE→) OPPOSITIONAL DEFIANCE DISORDER OR CONDUCT DISORDER

DX Code(s): ________________________________

PLANNED ADMISSION DATE: ______________________

HOSPITAL: ________________________________

NAME MEDICAID ID #

INFORMATION NEEDED (PLEASE CIRCLE ALL INCLUDED):

HISTORY & PHYSICAL:

OFFICE NOTES - PCP AND/OR SPECIALIST

PREVIOUS TREATMENTS:

MEDICATION

**CURRENT CLINICAL NOTES DOCUMENTING THE REASON FOR ADMISSION INCLUDING ABOVE INFORMATION MUST BE ATTACHED**

PHYSICIAN’S NAME: ________________________________

Last First Mi MEDICAID PROVIDER ID #:

ADDRESS: ______________________________________

CONTACT PERSON: ________________________________ PHONE #: ____________________________

*TO AVOID THE RISK OF NON-PAYMENT, PROVIDERS SHOULD CHECK ELIGIBILITY OF RECIPIENT PRIOR TO REQUEST FOR PRIOR APPROVAL REVIEW. IF THE RECIPIENT IS MANAGED CARE, PRIOR APPROVAL MUST BE OBTAINED THROUGH THE MANAGED CARE PROVIDER.

FAX TO: KePRO 1-855-300-0082

DHHS Psychiatric Prior Authorization Form – Inpatient–06/2012
SEND COMPLETED REQUEST FORM WITH MEDICAL RECORDS TO:
SCDHHS
CIRCUMCISION PRIOR APPROVAL REVIEW
FAX: (803) 255-8255

PATIENT NAME ______________________________________________________________
LAST      FIRST    MI

BIRTHDATE ___________________ *MEDICAID# ____________________________
MONTH/DAY/YEAR

PROCEDURE ___________________ CODE __________________________

DX CODE:______________________________

FACILITY __________________________
NAME ____________________________ NPI #

PLANNED SURGERY DATE _________________________________

*TO AVOID THE RISK OF NON–PAYMENT, PROVIDERS SHOULD CHECK ELIGIBILITY
OF RECIPIENT PRIOR TO REQUEST FOR PRIOR APPROVAL REVIEW. IF THE RECIPIENT
IS MANAGED CARE, PRIOR APPROVAL MUST BE OBTAINED THROUGH THE
MANAGED CARE PROVIDER.

PHYSICIAN’S NAME __________________________________________________________
LAST __________________________ FIRST __________________________ MI

ADDRESS ____________________________________________________________________

_________________________________ NPI: _____________

CONTACT PERSON _________________________ TELEPHONE (_____) _____________

DATE _________________ FAX NUMBER (_____) _____________

• OFFICE NOTES DOCUMENTING THE REQUESTED INFORMATION MUST BE ATTACHED
• ALL PERTINENT DOCUMENTATION FOR THE PROCEDURE SHOULD BE MAILED TOGETHER
• PROVIDERS WILL BE NOTIFIED OF DETERMINATION VIA FAX

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE

Revised: 02/01/11
**SBIRT INTEGRATED SCREENING TOOL**

* Fax the COMPLETED form to the patient’s plan and referral site and keep a copy in patient file

<table>
<thead>
<tr>
<th>Absolute Total Care</th>
<th>BlueChoice HealthPlan Medicaid</th>
<th>Molina</th>
<th>Molina Healthcare</th>
<th>Wellcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax: 877-285-1226</td>
<td>Fax: 855-580-2810</td>
<td>Fax: 866-423-3889</td>
<td>Wellcare Fax: 866-455-6562</td>
<td></td>
</tr>
<tr>
<td>Advice</td>
<td>First Choice by Select Health</td>
<td>SCOHMS (Feeder Service)</td>
<td>&amp; BlueChoice Healthcare</td>
<td></td>
</tr>
<tr>
<td>Fax: 888-781-4316</td>
<td>Fax: 866-533-5493</td>
<td>Fax: 803-355-6247</td>
<td>Fax: 803-870-9684</td>
<td></td>
</tr>
</tbody>
</table>

**PATIENT INFORMATION**

- **Patient’s last name:**
- **First:**
- **Middle:**
- **Language:**
- **Race:**
- **Ethnicity:**
- **Expected due date:**
- **Phone no:**
- **Street address:**
- **Member ID no:**

**PROVIDER INFORMATION**

- **Practice name:**
- **Group NPI:**
- **Individual NPI:**
- **Screening provider’s name:**
- **Phone no:**

**PATIENT SCREENING INFORMATION**

- **Parents**
  - Did any of your parents have a problem with alcohol or drug use? [ ] **YES** [ ] **NO**
  - Peers
    - Do any of your friends have a problem with alcohol or other drug use? [ ] **YES** [ ] **NO**
  - Partner
    - Does your partner have a problem with alcohol or other drug use? [ ] **YES** [ ] **NO**
  - Violence
    - Are you feeling at all unsafe in any way in your relationship with your current partner? [ ] **YES** [ ] **NO**
  - Emotional Health
    - Over the last few weeks, has worry, anxiety, depression or sadness made it difficult for you to do your work, get along with people or take care of things at home? [ ] **YES** [ ] **NO**
  - Past
    - In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications? [ ] **YES** [ ] **NO**
  - Present
    - In the past month, have you drank any alcohol or used other drugs? [ ] **YES** [ ] **NO**
      - How many days per month do you drink? [ ]
      - How many drinks on any given day? [ ]
      - How often did you have 4 or more drinks per day in the last month? [ ]
      - In the past month have you taken any prescription drugs? [ ] **YES** [ ] **NO**
  - Smoking
    - Have you smoked any cigarettes in the past three months? [ ] **YES** [ ] **NO**

Please provide additional details for any "yes" responses:

**ADVICE FOR BRIEF INTERVENTION**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **At Risk Drinking**
  - Non-Pregnant
  - Pregnant/Maternity Pregnancy
  - 7+ drinks/week
  - 8+ drinks/day
  - Any Use is Risky Drinking

**CONFIDENTIAL SBIRT REFERRAL INFORMATION**

- **Patient referred to:**
- (Check all that apply)
  - [ ] DMH
  - [ ] DAODAS
  - [ ] DHEC Quitline
  - [ ] Private provider (Name & NPI)
  - [ ] Domestic violence

- **Date of referral appointment (DD/MM/YY):**
- Date screened:
- [ ] Patient refused referral
- [ ] Referral not warranted
- [ ] Patient requested assistance

Women’s health can be affected by emotional problems, alcohol, tobacco, other drug use and domestic violence. Women’s health is also affected when these same problems are present in people close to us. By "alcohol," we mean beer, wine, wine coolers or liquor.

Physician’s Signature: ____________________________

*Adapted from Institute for Health & Recovery, (2013)*
Universal 17-P Authorization Form

Fax the COMPLETED form OR call the plan with the requested information.

☐ Absolute Total Care  ☐ BlueChoice HealthPlan  ☐ First Choice by Select Health  ☐ WellCare Health Plan, Inc.

☐ AdVICare  ☐ Molina Healthcare, Inc.
P: 866-781-4371  P: 855-237-6178
F: 888-781-4316  F: 855-571-3011

Date of Request for Authorization ____________________________ DOB ____________________________
Patient/Member Name ____________________________
Address (Street, Apt.#) ____________________________ City/State/Zip ____________________________
Phone ____________________________ Medicaid Number ____________________________
MCO ID Number ____________________________

☐ Pregnancy Information and History

G ______ T ______ P ______ A ______ L ________ (Note: A = abortion (spontaneous and medically induced) EDC ______
Last menstrual period __________ EDD ____________ Current Gestational age ____________ weeks
Bed Rest ☐ Yes ☐ No Experiencing Preterm Labor ☐ Yes ☐ No
(Home administration available if on bed rest)
Singleton Pregnancy ☐ Multiple Pregnancy
At least 16 weeks gestation ☐ Yes ☐ No** Major Fetal or Uterine Anomaly ☐ Yes ☐ No
Patient has a history of prior spontaneous singleton preterm birth between 20-36.6 weeks ☐ Yes ☐ No
Delivery was due to preterm labor or PPROM even if it resulted in C-section ☐ Yes ☐ No
Delivery was not due to medical indication, e.g. preeclampsia, abruption, etc. ☐ Yes ☐ No
Medication Allergies ____________________________ ☐ No known drug allergies
Other Pertinent Clinical Information: ____________________________

☐ Pharmacy Information

☐ Ship to patient’s home address  ☐ Ship to provider’s address
End Date of Service ____________________________
Shipping Preference: ☐ Regular Mail ☐ Ground ☐ Overnight
Ordering Physician’s Signature: ____________________________
Makena or 17-P Compound ____________________________

☐ Provider Information

Ordering Provider Name ____________________________ (Please Print)
Ordering Provider NPI ____________________________ Tax ID ____________________________
Address ____________________________ City/State/Zip ____________________________
Phone ____________________________ Fax ____________________________
Provider Type: ☐ OB/GYN ☐ Family Medicine ☐ MFM/Perinatology ☐ Other
Practice Name: ____________________________ Phone: ____________________________
Contact Person: ____________________________ Practice NPI: ____________________________
Fax: ____________________________

FOR MCO USE ONLY:

☐ Approved ☐ Denied Authorization # ____________________________ Number of Injections ____________________________
Date of Notification to Provider: ____________________________ Reviewer(s) name & title: ____________________________

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.

** Prescription may be written prior to 16 weeks, but the vial shipment may be withheld by the pharmacy until the 15th week
SCDHHS Behavioral Health Referral & Feedback Form
Physician Referral for Licensed Independent Practitioner Services

Date: ____________________  ( ) Initial  ( ) Follow-up

Referring Physician Name: ____________________

Address: ____________________  City: ____________________  State: ____________________  Zip: ____________________

Fax: (______) ____________________  Phone: (______) ____________________

Patient's Name: ____________________  DOB: ____________________

Parent’s Name (if minor): ____________________  Address: ____________________  Phone: ____________________

Date(s) Patient Seen: ____________________

Reason(s) for Referral: ____________________

Any Specific Questions or Requests: ____________________

__________________________

Referring Physician’s Printed Name/Signature

Thank you for evaluating this patient. To facilitate communication and treatment, please make copies of the following form to retain in the patient’s record; complete a form after initial assessment, complete additional forms periodically during treatment (as indicated) and when treatment is terminated, and mail or fax completed form(s) to the physician listed above. This is not a request for copies of psychotherapy notes, which require a signed consent to release. Thank you for your collaboration.

<table>
<thead>
<tr>
<th>Licensed Independent Practitioner’s Report</th>
</tr>
</thead>
</table>

Date(s) Patient Seen: ____________________

- [ ] Patient did not make appointment.
- [ ] Patient made an appointment but did not keep appointment.
- [ ] Patient not seen within 60 days.

Initial Diagnoses:

1. ____________________
2. ____________________
3. ____________________

Recommendations: ____________________

Medications Prescribed: ____________________

Follow-up Arranged or Provided by Consultant:

- [ ] Further diagnostic testing ____________________
- [ ] Individual psychotherapy ____________________
- [ ] Family psychotherapy ____________________
- [ ] Medication management ____________________
- [ ] Group psychotherapy ____________________
- [ ] Lab tests ____________________
- [ ] Return visit ____________________

Other Care Needed:

- [ ] Medication management by PCP ____________________
- [ ] Referrals recommended ____________________
- [ ] Follow-up recommended ____________________
- [ ] Other: ____________________

Name (type or print) Signature: ____________________

FAX to ____________________

# ____________________

Contact Person: ____________________
Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Form:
Beneficiary Informed Consent for Hereditary Cancer Genetic Testing

Instructions: Prior authorization request for BRCA 1 and BRCA 2 genes and BRCA Analysis Rearrangement testing for breast and ovarian cancer must be submitted to KEPRO. The Hereditary Breast and Ovarian Cancer Genetic Testing Prior Authorization Form must be completed and signed as outlined in the instructions below. The completed form with the original dated signature must be retained by the requesting physician in the beneficiary’s medical record. The form is subject to retrospective review.

The following forms, documents, and information must be submitted with the prior authorization request to KEPRO:

☐ The completed and signed Hereditary Breast and Ovarian Cancer Genetic Testing Prior Authorization Form
☐ Medical necessity documentation, including documentation of the efforts made to obtain the test results of previous comprehensive sequencing when appropriate
☐ Attestation for comprehensive testing. The attestation must indicate that familial BRCA testing results could not be obtained (as necessary).

Providers can refer to the South Carolina Department of Health and Human Services Physician Services Guide on the website at www.scdhhs.gov for specific information about coverage guidelines, prior authorization requirements and billing guidance.
Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Form:
Beneficiary Informed Consent for Hereditary Cancer Genetic Testing

**Section A: Beneficiary Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Medicaid ID#:</th>
<th>Date of birth:</th>
</tr>
</thead>
</table>

**Section B: Requested procedure or service information**

Check one:
- [ ] This request is for initial BRCA 1 and BRCA 2 testing.
- [ ] This request is for repeat BRCA 1 and BRCA 2 comprehensive sequencing testing because initial results are negative, or are not available, and large rearrangement testing is necessary. **Note:** The physician must make every reasonable effort to obtain from the previous physician any available BRCA 1 and BRCA 2 test results for the beneficiary and must submit documentation of the efforts made to obtain the test results of previous comprehensive sequencing to KEPRO with the prior authorization request.

<table>
<thead>
<tr>
<th>Expected dates of service</th>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure code requested</td>
<td></td>
<td>Procedure code description</td>
</tr>
</tbody>
</table>

**Comments:**

**Section C: Medical necessity information – Submit clinical notes to support genetic testing request.**

<table>
<thead>
<tr>
<th>Diagnosis code(s):</th>
<th>Medical necessity:</th>
</tr>
</thead>
</table>

Information about close blood relatives from the same side of the family who have been diagnosed with ovarian, breast, prostate (Gleason score of 7 or greater), or pancreatic cancer, or who have had a positive BRCA1 or BRCA2 test results with no diagnosis of cancer:

<table>
<thead>
<tr>
<th>Relative #1</th>
<th>a. Age</th>
<th>b. Gender</th>
<th>c. Cancer</th>
<th>d. Relationship to Beneficiary</th>
<th>e. Positive BRCA1 or BRCA2 Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative #2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative #3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative #4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For full sequence or gene variants: Positive familial BRCA testing results could not be obtained [ ] Yes [ ] No

Ethnic decent of beneficiary if associated with deleterious mutations (including, but not limited to: Ashkenazi Jewish, Icelandic Swedish, or Hungarian):

<table>
<thead>
<tr>
<th>Physician’s name:</th>
<th>Telephone number:</th>
<th>Fax number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s NPI:</td>
<td>Facility/Office NPI:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician’s signature:</th>
<th>Date signed:</th>
</tr>
</thead>
</table>
Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Form:
Beneficiary Informed Consent for Hereditary Cancer Genetic Testing

**Section D: Requirements for genetic counseling and beneficiary consent** – The beneficiary must receive pre-testing genetic counseling and provide consent for genetic testing before the prior authorization is submitted and the blood specimen is obtained. Documentation of the genetic counseling must be maintained in the beneficiary’s medical record.

<table>
<thead>
<tr>
<th>Date the beneficiary received pre-testing genetic counseling:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of person who provided pre-testing genetic counseling:</td>
</tr>
<tr>
<td>Qualifications of person providing pre-testing genetic counseling:</td>
</tr>
<tr>
<td>Counselor telephone number:</td>
</tr>
<tr>
<td>Date beneficiary’s consent was obtained for the genetic testing:</td>
</tr>
</tbody>
</table>

**Section E: Laboratory provider information**

<table>
<thead>
<tr>
<th>Provider name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address/City/Zip</td>
</tr>
<tr>
<td>Contact person:</td>
</tr>
<tr>
<td>Telephone number:</td>
</tr>
<tr>
<td>NPI:</td>
</tr>
</tbody>
</table>
SCDHHS Prior Authorization Form for Fetal DNA Blood Test
Codes 81420, 81422 and 81507

Patient Information:

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>SC Medicaid Number:</th>
<th>Date of Birth:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code:</th>
<th>Procedure Request:</th>
<th>Date of Service:</th>
</tr>
</thead>
</table>

Requesting Physician Information:

<table>
<thead>
<tr>
<th>Physician Name:</th>
<th>SC Medicaid Provider Number:</th>
<th>NPI Number:</th>
</tr>
</thead>
</table>

South Carolina Department of Health and Human Services (SCDHHS) Medical Necessity Criteria for Fetal DNA Blood Testing:

Please check appropriate boxes supporting request for prior authorization

☐ Underwent pretest counseling;
☐ A cell-free fetal DNA test has not been performed yet in this pregnancy;
☐ Current pregnancy not a multiple gestation;
☐ Current pregnancy greater than or equal to ten (10) weeks and less than twenty-three (23) weeks at the time the blood will be drawn
☐ High risk for fetal aneuploidy as evidenced by one of the following:
  ☐ Maternal age greater than or equal to thirty-five (35) years at delivery;
  ☐ Maternal history of a child affected with trisomy;
  ☐ Abnormal ultrasound findings;
  ☐ Positive test result for aneuploidy, including first trimester, sequential or integrated screen or quadruple screen;
  ☐ A parent carrying a balanced Robertsonian translocation with increased risk of trisomy 13 or trisomy 21.

Requesting Physician Signature: __________________________ Date: __________________________

The form should be completed by the clinician who has a thorough knowledge of the member’s current clinical presentation and her treatment history. Please complete all parts as clearly and specifically as possible. Omissions, generalities and illegibility will result in the form being returned, delaying requested services.

Required Documentation:

☐ Completed SCDHHS Prior Authorization Form for Fetal DNA Blood Test
☐ Medical Records/Documentation

All request submitted via fax must include supporting medical and clinical information:

KePro Fax Number: (855) 300-0082
KePro Phone Number: (855) 326-5219