

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
	Duplicate Remittance Advice Request Form	09/2017
	Claim Reconsideration Form	11/2018
CMS-1500 (02/12)	Sample Claim Showing TPL Payment with NPI	02/2012
	Sample Remittance Advice (four pages)	04/2014
	Healthy Mothers, Healthy Futures Maternity Health Education Checklist (two pages)	
	Alcohol and Drug Medical Assessment (two pages)	09/1990
	DHHS Pediatric Sub-Specialists Certification Form	06/2015
	Abortion Statement	
DHHS 687	Consent For Sterilization	05/2023
	Surgical Justification Review for Hysterectomy	07/2017
	Request for Prior Approval Review	06/2012
	Allied Profession Supervision Form	08/2013
	Referral Request Form for Out-of-State Services (three pages)	10/2022
	Transplant Prior Authorization Request Form & Instructions (two pages)	05/2022
	Mental Health Form	09/2013
	Psychiatric Prior Authorization Form – Inpatient	06/2012
	Circumcision Prior Authorization Form	02/2011
	BOI Universal Screening Tool	04/2017

FORMS

Number	Name	Revision Date
	Universal 17-P Authorization Form	12/2013
	SCDHHS Behavioral Health Referral and Feedback Form	12/2013
	Hereditary Breast and Ovarian Cancer (HBOC)	08/2019
	SCDHHS Prior Authorization Form for Fetal DNA Blood Test	02/2020
	Pharmacogenetic Genetic Testing Prior Authorization Request Form	03/2024



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

CONFIDENTIAL COMPLAINT

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

PROGRAM INTEGRITY

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

NPI or MEDICAID PROVIDER ID: (if applicable)

MEDICAID RECIPIENT ID NUMBER: (if applicable)

ADDRESS OF SUSPECT:

LOCATION OF INCIDENT:

DATE OF INCIDENT:

COMPLAINT:

NAME OF PERSON REPORTING: (Please print)

SIGNATURE OF PERSON
REPORTING:

DATE OF REPORT

ADDRESS OF PERSON REPORTING:

TELEPHONE NUMBER OF PERSON REPORTING:

SIGNATURE: (SCDHHS Representative Receiving Report)

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

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

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Grid for Original CCN (15 boxes)

Provider ID:

Grid for Provider ID (6 boxes)

NPI:

Grid for NPI (10 boxes)

Recipient ID:

Grid for Recipient ID (10 boxes)

Adjustment Type:

- Void, Void/Replace

Originator:

- DHHS, MCCS, Provider, MIVS

Reason For Adjustment: (Fill One Only)

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

For Agency Use Only

Analyst ID:

Grid for Analyst ID (6 boxes)

- Hospital/Office Visit included in Surgical Package, 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: _____



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

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

Contact Person: _____ Phone #: _____ Date: _____

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

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

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

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

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

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

Fax:	or	Mail:
803-252-0870		Post Office Box 101110
		Columbia, SC 29211-9804



**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

**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



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)

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

PROVIDER ID.					PROFESSIONAL SERVICES					PAYMENT DATE	PAGE		
AB00080000	DEPT OF HEALTH AND HUMAN SERVICES				REMITTANCE ADVICE				02/14/2014				1
	SOUTH CAROLINA MEDICAID PROGRAM												
PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE 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 01		101713	71010	27.00 27.00	6.72 6.72	P P	1112233333	M CLARK		026	0.00	0.00
ABB2AA	1403004804012700A 01		101713	74176	259.00 259.00	0.00 0.00	S S	1112233333	M CLARK		026	0.00	0.00
ABB3AA	1403004805012700A 01 02		071913 071913	A5120 A4927	24.00 12.00 12.00	0.00 0.00 0.00	R R R	1112233333	M CLARK		000 000	0.00	0.00 0.00
TOTALS				3	310.00				Edits: L00 946 L02 852 08/30/13			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

\$0.00

CERTIFIED AMT

MEDICAID PG TOT

\$286.46

MEDICAID TOTAL

0.00

CHECK TOTAL

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

CHECK NUMBER

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.	PROFESSIONAL SERVICES	PAYMENT DATE	PAGE
AB00080000	DEPT OF HEALTH AND HUMAN SERVICES	02/28/2014	1
	SOUTH CAROLINA MEDICAID PROGRAM		

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	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		021814	S0315	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		100213	S0315	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		100213	S0315	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

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.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>CERT. PG TOT</td> <td>\$0.00</td> </tr> <tr> <td>CERTIFIED AMT</td> <td></td> </tr> </table>	CERT. PG TOT	\$0.00	CERTIFIED AMT		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>MEDICAID PG TOT</td> <td>\$286.46</td> </tr> <tr> <td>MEDICAID TOTAL</td> <td>0.00</td> </tr> <tr> <td>CHECK TOTAL</td> <td></td> </tr> </table>	MEDICAID PG TOT	\$286.46	MEDICAID TOTAL	0.00	CHECK TOTAL		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 CHECK NUMBER
CERT. PG TOT	\$0.00												
CERTIFIED AMT													
MEDICAID PG TOT	\$286.46												
MEDICAID TOTAL	0.00												
CHECK TOTAL													

Sample Remittance Advice (page 3)

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

PROVIDER ID.	DEPT OF HEALTH AND HUMAN SERVICES	CLAIM ADJUSTMENTS	PAYMENT DATE	PAGE
AB11110000	SOUTH CAROLINA MEDICAID PROGRAM		02/28/2014	2

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 LAST NAME I I	M F M I	ORG CHECK DATE	ORIGINAL CCN
ABB222222	1405200077700000U				513.00-	197.71-	P	1112233333	CLARK	M	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-						

SAMPLE ONLY

PROVDER INCENTIVE CREDIT AMOUNT	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	TO BE REFUNDED IN THE FUTURE
0.00	0.00	\$243.71	0.00	0.00
		ADJUSTMENTS		
		\$193.71-		
	YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PROVIDER NAME AND ADDRESS
	0.00	\$50.00	4197304	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.	DEPT OF HEALTH AND HUMAN SERVICES	ADJUSTMENTS	PAYMENT DATE	PAGE
AB11110000	SOUTH CAROLINA MEDICAID PROGRAM		02/28/2014	3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME I I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	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

SAMPLE ONLY

PROVIDER INCENTIVE CREDIT AMOUNT	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	TO BE REFUNDED IN THE FUTURE
0.00	0.00	0.00	0.00	0.00
		ADJUSTMENTS		
		-4338.95	0.00	
	YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PROVIDER NAME AND ADDRESS
	0.00	0.00		ABC HEALTH PROVIDER PO BOX 000000 FLORENCE SC 00000

HEALTHY MOTHERS, HEALTHY 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.

TOPIC	COMPLETED	DATE(S)
OFFICE SERVICES AND ROUTINES: Information about hours, appointments, lab tests, and other general procedures.	<input type="checkbox"/>	_____
GENERAL INSTRUCTION ABOUT PREGNANCY: such as hygiene, exercise, sexuality, medication, and importance of prenatal care.	<input type="checkbox"/>	_____
FETAL GROWTH AND DEVELOPMENT: how the baby develops month by month and physical and psychological changes experienced by the mother; including comfort measures.	<input type="checkbox"/>	_____
NUTRITION: including routine prenatal diet instruction. (Be sure to make referral to WIC PROGRAM)	<input type="checkbox"/>	_____
EXPLANATION OF EDC: Understanding the due date.	<input type="checkbox"/>	_____
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.	<input type="checkbox"/>	_____
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	<input type="checkbox"/>	_____
PROCESS OF LABOR AND DELIVERY: discussion of physical process of labor and delivery, including psychological changes experienced.	<input type="checkbox"/>	_____
METHODS OF ANESTHESIA: Information on types of anesthesia with discussion of benefits, risks and alternatives; also pain medication.	<input type="checkbox"/>	_____
CESAREAN SECTION: discussion of what it is and what are the usual indications including risks and benefits	<input type="checkbox"/>	_____
RELAXATION AND BREATHING EXERCISES: preparation for labor including demonstration and practice of exercises and breathing techniques	<input type="checkbox"/>	_____
BREASTFEEDING: factors to consider in decision making and preparation of the breasts Note: Possible referral to La Leche or Breastfeeding Support	<input type="checkbox"/>	_____

(Continued on Reverse)

MATERNITY EDUCATION CHECKLIST (Continued)

PREPARATION OF OTHER FAMILY MEMBERS: sibling preparation and needs of other family members before and after birth of child; father support and involvement.

DATE(S)

DELIVERY ARRANGEMENTS: Hospital tours, expectations and procedures during delivery and hospital stay.

POSTPARTUM CARE: Immediate postpartum needs and six weeks check-up and physical care at home, including psychological needs and adjustments.

FAMILY PLANNING: Importance of family planning; risks of short inter-conceptual period and discussion of all methods.

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.

OTHER: Note special areas covered

REFERRAL:

WIC PROGRAM:

Date: _____

HRCF (if applicable)
High Risk Channeling Project

Date: _____

OTHER

Date: _____

Date: _____

SIGNATURE:

ATTENDING PHYSICIAN

Alcohol and Drug Medical Assessment

Patient's Name (Last, First, MI) and I.D. #	
Medicaid Client #	Date of Medical Assessment
Physician's Name and Address	
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 1: PHYSICIAN DEMOGRAPHIC INFORMATION (PLEASE PRINT)

Name (First, Middle, Last):		NPI#:
Physical Location Address:		Suite/Unit #:
City:	State:	ZIP+4:
E-mail Address:		
Telephone Number:		Fax Number:
Mailing Address (if different from physical location address):		
City:	State:	ZIP+4:

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)

<input type="checkbox"/> Adolescent Medicine	<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Nephrology	<input type="checkbox"/> Pulmonology
<input type="checkbox"/> Allergy	<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Neurology	<input type="checkbox"/> Radiology
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Gastroenterology/Nutrition	<input type="checkbox"/> Neurological Surgery	<input type="checkbox"/> Rheumatology
<input type="checkbox"/> Cardiothoracic Surgery	<input type="checkbox"/> Genetics	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Surgery
<input type="checkbox"/> Child Abuse Pediatrics	<input type="checkbox"/> Hematology/Oncology	<input type="checkbox"/> Orthopedic Surgery	<input type="checkbox"/> Urology
<input type="checkbox"/> Critical Care	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Otolaryngology	
<input type="checkbox"/> Developmental-Behavioral Pediatrics	<input type="checkbox"/> Neonatology	<input type="checkbox"/> Psychiatry	

CERTIFICATION

I hereby certify that:

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

Patient Heading	As a Group	As an Individual	TOTAL
Number of patients seen			
Number of MediCAID patients			
Number of patients 18 and under			
Number of patients with MediCAID 18 and under			

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

Contact Person Name (please print):	Contact Email Address:
Contact Telephone Number:	Contact Fax Number:

Please **FAX** or **MAIL** completed/signed form to:
Medicaid Provider Enrollment
FAX: 803-870-9022
MAIL: POB 8809, Columbia, SC 29202-8809

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

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ . When I first asked _____
Doctor or Clinic

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 a _____ . The discomforts, risks
Specify Type of Operation

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: _____
Date

I, _____, hereby consent of my own free will to be sterilized by _____
Doctor or Clinic

by a method called _____ . My
Specify Type of Operation
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 *Date*

You are requested to supply the following information, but it is not required: (*Ethnicity and Race Designation*) (please check)

- Ethnicity:*
 Hispanic or Latino American Indian or Alaska Native
 Not Hispanic or Latino Asian
 Black or African American
 Native Hawaiian or Other Pacific Islander
 White

■ 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*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
Name of Individual
consent form, I explained to him/her the nature of sterilization operation _____, the fact that it is
Specify Type of Operation

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*

Facility

Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

_____ on _____
Name of Individual *Date of Sterilization*

I explained to him/her the nature of the sterilization operation _____, the fact that it is
Specify Type of Operation

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*



State of South Carolina
 Department of Health and Human Services

Please return signed original certificate to:

Mailing Address:

SC Dept. of Health and Human Services
 Behavioral Health Services
 Post Office Box 8206
 Columbia, South Carolina 29202-8206
 Fax: (803) 255-8204

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:	

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

Henry McMaster GOVERNOR
 Robert M. Kerr DIRECTOR
 P.O. Box 8206 > Columbia, SC 29202
 www.scdhhs.gov

Send to: SCDHHS Bureau of Provider and Support Services Attn: Out-of-State Coordinator Fax: 803-255-8255	Date:	# of Pages (including cover):
	Point of Contact Information	
	Name	
	Phone	
	Fax	
	Email	

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: _____

Confidentiality Note:

THIS MESSAGE IS INTENDED FOR THE USE OF THE PERSON OR ENTITY TO WHICH IT IS ADDRESSED AND MAY CONTAIN INFORMATION, INCLUDING HEALTH INFORMATION, THAT IS PRIVILEGED, CONFIDENTIAL, AND THE DISCLOSURE OF WHICH IS GOVERNED BY APPLICABLE LAW. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS INFORMATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS IN ERROR, PLEASE NOTIFY US IMMEDIATELY.
 THANK YOU.

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.

Member Information				
Name	Date of Birth	SC Medicaid Number	Name of Guardian	Contact Phone Number
Will member require meals, lodging and transportation (ancillary) assistance? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Services are (Select one): <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient				
Ancillary assistance is provided for the member and one (1) escort for approved services, where applicable. Adequate advanced notice and <u>prior approval</u> from SCDHHS are mandatory prior to the broker arranging travel. Hotel accommodations are for outpatient services <i>only</i>. Retroactive reimbursement will not be approved.				
Referring Provider Information				
Facility Name	Provider Name	NPI SC Medicaid Legacy ID #	Contact Phone Number	
Clinical Information				
Condition requiring treatment				
<p style="text-align: center;"><u>REQUIRED</u></p> <p><i>Brief explanation of medical need to receive services outside of the South Carolina Medicaid Service Area (SCMSA).</i></p> <p>The SCMSA includes all of South Carolina and regions of North Carolina and Georgia within 25 miles of the South Carolina border.</p>				
ICD-10 Diagnosis Code(s)			HCPCS/CPT Procedure Code(s)	
Patient is being referred to:				
Facility:		Provider(s):		
Date of service (if no appointment is scheduled, enter "tentative")			Date of return (refers to length of stay for the service)	

- 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.

Provider Information	
<input type="checkbox"/> Individual <input type="checkbox"/> Facility	
<i>Provider Name</i>	<i>NPI SC Medicaid Legacy ID #</i>
<i>Contact Phone Number</i>	<i>Fax Number</i>
<i>Member Name</i>	<i>Member Date of Birth</i>

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	
REFERRING PHYSICIAN	
NAME OF REFERRING PHYSICIAN: _____	NPI: _____ SC MEDICAID #: _____
TYPE OF TRANSPLANT: _____ TYPE OF ORGAN BEING RECEIVED: Living _____ Cadaveric _____	
EXPECTED DATE OF SERVICE: _____	
RENDERING PHYSICIAN/FACILITY	
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	
ICD-10 DIAGNOSIS CODE(S)	DESCRIPTION
PROCEDURE CODE(S)	DESCRIPTION

REQUIRED DOCUMENTATION
Letter of Medical Necessity for the transplant, including the following: <ul style="list-style-type: none"> 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

Beneficiary Information	
Beneficiary's Name:	
Medicaid ID #:	
Date of Birth:	

Provider Information	
Individual NPI:	
Organization NPI:	
Service Location Address:	
City & State:	

DSM-IV TR Diagnosis

Axis I _____ / _____ / _____ Axis II _____ / _____ Axis III _____ / _____

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)

Aggression	0 1 2 3 4	Depressions	0 1 2 3 4	Relationship Problems	0 1 2 3 4
Alcohol/Substance Use	0 1 2 3 4	Hallucinations	0 1 2 3 4	Side Effects	0 1 2 3 4
Anxiety/Panic	0 1 2 3 4	Impulsivity	0 1 2 3 4	Sleep Effects	0 1 2 3 4
Appetite Disturbance	0 1 2 3 4	Job/School Problems	0 1 2 3 4	Sleep Disturbance	0 1 2 3 4
Attention/Concentration	0 1 2 3 4	Mania	0 1 2 3 4	Weight Loss	0 1 2 3 4
Deficit in ADLs	0 1 2 3 4	Medical Illness	0 1 2 3 4	Other	0 1 2 3 4
Delusions	0 1 2 3 4	Memory	0 1 2 3 4	Current Stressors	0 1 2 3 4

Services

- | | | | |
|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> 90833 | <input type="checkbox"/> 90846 | <input type="checkbox"/> 90853 | <input type="checkbox"/> 90837 |
| <input type="checkbox"/> 90836 | <input type="checkbox"/> 90847 | <input type="checkbox"/> 90832 | <input type="checkbox"/> 96102 |
| <input type="checkbox"/> 90838 | <input type="checkbox"/> 96101 | <input type="checkbox"/> 90834 | |

Current Medications	Name	Dose	Frequency	Side Effects
<input type="checkbox"/> New	1. _____	_____	_____	_____
<input type="checkbox"/> New	2. _____	_____	_____	_____
<input type="checkbox"/> New	3. _____	_____	_____	_____
<input type="checkbox"/> New	4. _____	_____	_____	_____
Compliance	<input type="checkbox"/> >90%	<input type="checkbox"/> 50-90%	<input type="checkbox"/>	<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:
KePRO FAX#: 1-855-300-0082, KePRO Customer Service Phone#: 1-855-326-5216, KePRO website: <http://scdhhs.KePRO.com>.**

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.

Behavioral Health Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

SBIRT INTEGRATED SCREENING TOOL

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

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Absolute Total Care
Fax: 877-285-3226 | <input type="checkbox"/> BlueChoice HealthPlan Medicaid
Fax: 855-580-2810 | <input type="checkbox"/> Molina
Fax: 866-423-3889 | <input type="checkbox"/> Wellcare
Fax: 866-455-6562 |
| <input type="checkbox"/> Advicare
Fax: 888-781-4316 | <input type="checkbox"/> First Choice by Select Health
Fax: 866-533-5493 | <input type="checkbox"/> SCDHHS (Fee-For-Service)
Fax: 803-255-8247 | <input type="checkbox"/> BlueCross BlueShield of South Carolina & BlueChoice HealthPlan
Fax: 803-870-9884 |

PATIENT INFORMATION			
Patient's last name:	First:	Middle:	Language:
Phone no: ()	Street address:	Member ID no:	Race:
Expected due date:	Ethnicity:		
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?	<input type="radio"/> YES		<input type="radio"/> NO
Peers Do any of your friends have a problem with alcohol or other drug use?	<input type="radio"/> YES		<input type="radio"/> NO
Partner Does your partner have a problem with alcohol or other drug use?		<input type="radio"/> YES	<input type="radio"/> NO
Violence Are you feeling at all unsafe in any way in your relationship with your current partner?	<input type="radio"/> YES		<input type="radio"/> 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?		<input type="radio"/> YES	<input type="radio"/> NO
Past In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?		<input type="radio"/> YES	<input type="radio"/> NO
Present In the past month, have you drunk any alcohol or used other drugs? 1. How many days per month do you drink? _____ 2. How many drinks on any given day? _____ 3. How often did you have 4 or more drinks per day in the last month? _____ 4. In the past month have you taken any prescription drugs?		<input type="radio"/> YES	<input type="radio"/> NO
Smoking Have you smoked any cigarettes in the past three months?		<input type="radio"/> YES	<input type="radio"/> NO
Please provide additional details for any "yes" responses:		Review risk	Review domestic violence resources
		Review substance use, set healthy goals	Consider mental evaluation

ADVICE FOR BRIEF INTERVENTION			
	Y	N	N/A
Did you State your medical concern?			
Did you Advise to abstain or reduce use?			
Did you Check patient's reaction?			
Did you Refer for future assessment?			

At Risk Drinking	
Non-Pregnant	Pregnant/Planning Pregnancy
7+ drinks/week 3+ drinks/day	Any Use is Risky Drinking

CONFIDENTIAL SBIRT REFERRAL INFORMATION				
Patient referred to: (Check all that apply)	<input type="checkbox"/> DMH	<input type="checkbox"/> DAODAS	<input type="checkbox"/> DHEC Quitline Fax: 800-483-3114	<input type="checkbox"/> Private provider (Name & NPI)
Date of referral appointment (DD/MM/YY):	Date screened:	<input type="checkbox"/> Patient refused referral	<input type="checkbox"/> Referral not warranted	<input type="checkbox"/> Patient requested assistance
<input type="checkbox"/> Domestic violence 803-256-2900				

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

Physician's Signature: _____

**Adapted from Institute for Health & Recovery, (2015)*

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.
P: 803-933-3689 P: 866-902-1689 P: 888-559-1010 x55251 P: 888-588-9842
F: 866-918-4451 F: 800-823-5520 F: 866-533-5493 F: 866-458-9245

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

Date of Request for Authorization _____
Patient/Member Name _____ DOB _____
First Middle Last
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 PPRM 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 End Date of Service _____

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: _____ Practice NPI: _____

Contact Person: _____ Phone: _____ 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: _____
 (Street/PO Box) 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.

Licensed Independent Practitioner's Report

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: _____

<p>Follow-up Arranged or Provided by Consultant:</p> <input type="checkbox"/> Further diagnostic testing _____ <input type="checkbox"/> Individual psychotherapy <input type="checkbox"/> Family psychotherapy <input type="checkbox"/> Medication management <input type="checkbox"/> Group psychotherapy <input type="checkbox"/> Lab tests <input type="checkbox"/> Return visit _____	<p>Other Care Needed:</p> <input type="checkbox"/> Medication management by PCP <input type="checkbox"/> Referrals recommended _____ <input type="checkbox"/> Follow-up recommended _____ <input type="checkbox"/> 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					
Name:					
Medicaid ID#:			Date of birth:		
Section B: Requested procedure or service information					
Check one:					
<input type="checkbox"/> This request is for initial BRCA 1 and BRCA 2 testing.					
<input type="checkbox"/> 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.					
Expected dates of service		From:		To:	
Procedure code requested			Procedure code description		
Comments:					
Section C: Medical necessity information – Submit clinical notes to support genetic testing request.					
Diagnosis code(s):					
Medical necessity:					
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:					
Relative	a. Age	b. Gender	c. Cancer	d. Relationship to Beneficiary	e. Positive BRCA1 or BRCA2 Results
Relative #1:					
Relative #2:					
Relative #3:					
Relative #4:					
For full sequence or gene variants: Positive familial BRCA testing results could not be obtained					<input type="checkbox"/> Yes <input type="checkbox"/> No
Ethnic decent of beneficiary if associated with deleterious mutations (including, but not limited to: Ashkenazi Jewish, Icelandic Swedish, or Hungarian):					
Physician's name:					
Telephone number:			Fax number:		
Physician's NPI:			Facility/Office NPI:		
Physician's signature:			Date signed:		

**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.	
Date the beneficiary receive pre-testing genetic counseling:	
Name of person who provided pre-testing genetic counseling:	
Qualifications of person providing pre-testing genetic counseling:	
Counselor telephone number:	Counselor fax number:
Date beneficiary’s consent was obtained for the genetic testing:	
Section E: Laboratory provider information	
Provider name:	
Address/City/Zip	
Contact person:	
Telephone number:	Fax number:
NPI:	Tax ID:



SCDHHS Prior Authorization Form for Fetal DNA Blood Test

Codes 81420, 81422 and 81507

Patient Information:

Patient Name:	SC Medicaid Number:	Date of Birth:
Diagnosis Code:	Procedure Request:	Date of Service:

Requesting Physician Information:

Physician Name:	SC Medicaid Provider Number:	NPI Number:
-----------------	------------------------------	-------------

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

Pharmacogenetic Genetic Testing Prior Authorization Request Form
KEPRO-SCDHHS QIO

KEPRO-SCDHHS QIO now requires any Medicaid Provider submitting Prior Authorizations using their National Provider Identifier (NPI) with their 9 digit zip code. If you do not know your 9-digit zip code then please visit: <http://zip4.usps.com/zip4/welcome.jsp>

Submit fax request for Prior Authorization to: 1-855-300-0082

Requests may be submitted up to 30 days prior to scheduled procedures/services, provided Member is eligible.

1. Date of Request (mm/dd/yyyy)		2. Review Type (check one if applicable) <input type="checkbox"/> Prior Authorization <input type="checkbox"/> Retrospective Prepayment Review (Date notified of eligibility: _____)		
3. Member Medicaid ID Number (10-digit Number):	4. Member Last Name:	5. Member First Name:	6. Date of Birth (mm/dd/yyyy):	7. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
8. a. NPI/Requesting Service Provider Name & ID Number: b. 9-digit Zip Code (Mandatory)		9. Treatment Setting <input type="checkbox"/> Outpatient LAB	10. Primary Diagnosis Code: (enter up to 5) 1. 2. 3. 4. 5.	
11. a. NPI/Rendering Provider Name and ID Number: b. 9-digit Zip Code (Mandatory)		12. Prior Auth Service Type: <input type="checkbox"/> LAB	CPT CODE: <input type="checkbox"/> 81418	
13. NPI/ORDERING Provider Name and ID Number:				

14. Contact Name:
15. Contact Telephone Number:
16. Contact Fax Number:

****Please submit this form in addition to the medical records that support the genome testing. This may include H&P, current treatment plan and medications.**

The information contained in this facsimile is legally privileged and confidential information intended only for use of the entity named above. If the reader of this message is not the intended member, employee, or agent responsible for delivering this message, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF CONFIDENTIAL INFORMATION IS STRICTLY PROHIBITED AND COULD SUBJECT YOU TO LEGAL ACTION. If you received this in error, please notify KEPRO by phone or fax at the appropriate number listed above, and destroy the misdirected document. Thank you.
SC QIO OP Fax Form

Approved:

Pharmacogenetic Genetic Testing Prior Authorization Request Form
KEPRO-SCDHHS QIO

INSTRUCTIONS FOR OUTPATIENT ELECTRONIC FAX FORM

This FAX submission form is required for faxed Pharmacogenetic testing Reviews. When submitting the fax, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being denied or returned via FAX for additional information.

If KEPRO determines that your request meets appropriate coverage criteria guidelines, the Prior Authorization (PA AUTH) number provided by KEPRO will be provided to you via Fax back process and will be available to providers registered on the web-based program Atrezzo (<https://portal.kepro.com>). **This excludes weekends and holidays.**

1. **Date of Request:** The date you are submitting the Prior Authorization request.
2. **Review Type:** Place a or in the appropriate box. Requests must be received on or before services are rendered. Please refer to the Provider Manuals regarding Retrospective review policy and procedure for detailed information regarding the services being requested. If retrospective eligibility, enter the date that the provider was notified of retrospective eligibility.
3. **Member Medicaid ID Number:** It is the provider's responsibility to ensure the Member's Medicaid number is valid. This should contain 10 digits
4. **Member Last Name:** Enter the Member's last name exactly as it appears on the Medicaid card.
5. **Member First Name:** Enter the Member's first name exactly as it appears on the Medicaid card.
6. **Date of Birth:** Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).
7. **Gender:** Please place a or to indicate the sex of the member.
8. **a. NPI Requesting /Service Provider Name and ID Number:** Enter the requesting/service provider name and National Provider Identifier (NPI).
b. 9-digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI number being submitted.
9. **Treatment Setting:** Default to OUTPATIENT/ LAB
10. **Primary Diagnosis Code /Description:** Provide the primary diagnosis code and/or description indicating the reason for service(s).
11. **a. NPI Rendering Provider Name and ID Number:** Enter the rendering provider name and National Provider Identifier (NPI) for the provider performing the service.
b. 9-digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI number being submitted,
12. **Prior AUTH Service Type and Procedure Code:** This request for is specifically for Pharmacogenetic Testing, CPT 81418
13. **NPI Ordering Provider:** must be a board-certified psychiatrist or psychiatrist extender
14. **Contact Information** Please put the name and contact number of the person completing the request so we may contact you if we have any questions

**** Reminder: Prior Authorization is based on medical necessity and is not a guarantee of payment. Providers are responsible for checking patient eligibility and following the rules and regulations outlined in the SCDHHS provider policy and billing manuals.**

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SC QIO OP Fax Form

Approved: