

## FORMS

Number	Name	Revision Date
DHHS 126	<a href="#">Confidential Complaint</a>	06/2007
DHHS 130	<a href="#">Claim Adjustment Form 130</a>	03/2007
DHHS 205	<a href="#">Medicaid Refunds</a>	01/2008
DHHS 931	<a href="#">Health Insurance Information Referral Form</a>	02/2018
	<a href="#">Reasonable Effort Documentation</a>	04/2014
	<a href="#">Electronic Funds Transfer (EFT) Authorization Agreement</a>	07/2019
	<a href="#">Duplicate Remittance Advice Request Form</a>	09/2017
	<a href="#">Claim Reconsideration Form</a>	11/2018
CMS-1500 (02/12)	<a href="#">Sample Health Insurance Claim Form</a>	02/2012
	<a href="#">Sample Remittance Advice (four pages)</a>	04/2014
	<a href="#">Allied Professional Registration Form</a>	04/2017
	<a href="#">LISW Allied Professional Registration Form</a>	04/2017
	<a href="#">Mental Health Form</a>	04/2013
	<a href="#">Alcohol and Drug Medical Assessment (two pages)</a>	09/2024
	<a href="#">Request for Prior Approval Review</a>	09/2024
	<a href="#">Allied Profession Supervision Form</a>	09/2024
	<a href="#">BOI Universal Screening Tool</a>	09/2024
	<a href="#">Universal 17-P Authorization Form</a>	09/2024
	<a href="#">SCDHHS Behavioral Health Referral and Feedback Form</a>	09/2024



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

For Agency Use Only

Analyst ID:

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 Form for Medicaid Refunds

**Purpose:** This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

**Items 1, 2 or 3, 4, 5, 6, & 7 must be completed.**

**Attach appropriate document(s) as listed in item 8.**

**1. Provider Name:** \_\_\_\_\_

**2. Medicaid Legacy Provider #**   
(Six Characters)

**OR**

**3. NPI#**  **& Taxonomy**

**4. Person to Contact:** \_\_\_\_\_

**5. Telephone Number:** \_\_\_\_\_

**6. Reason for Refund:** [check appropriate box]

Other Insurance Paid (please complete **a – f** below and attach insurance EOMB) **a** Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization **b** Insurance Company Name  
**c** Policy #: \_\_\_\_\_ **d** Policyholder: \_\_\_\_\_  
**e** Group Name/Group: \_\_\_\_\_  
**f** Amount Insurance Paid: \_\_\_\_\_

Medicare  
 ( ) Full payment made by Medicare  
 ( ) Deductible not due  
 ( ) Adjustment made by Medicare  
 Requested by DHHS (please attach a copy of the request)

Other,  describe in detail reason for refund: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**7. Patient/Service Identification:**

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

**8. Attachment(s):** [Check appropriate box]

- Medicaid Remittance Advice (required)
- Explanation of Benefits (EOMB) from Insurance Company (if applicable)
- Explanation of Benefits (EOMB) from Medicare (if applicable)
- Refund check

Make all checks payable to: South Carolina Department of Health and Human Services

Mail to: SC Department of Health and Human Services

Cash Receipts

Post Office Box 8355

Columbia, SC 29202-8355

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).

<b>Fax:</b>	<b>or</b>	<b>Mail:</b>
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.**

**South Carolina Department of Health and Human Services  
Electronic Funds Transfer (EFT) Authorization Agreement**

**PROVIDER INFORMATION**

Provider Name \_\_\_\_\_

Doing Business As Name (DBA) \_\_\_\_\_

**Provider Address**

Street \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_

Zip Code/Postal Code \_\_\_\_\_ Medicaid Provider Number \_\_\_\_\_

Provider Federal Identification Number (TIN) or \_\_\_\_\_

Employer Identification Number (EIN) \_\_\_\_\_

National Provider Identifier (NPI) \_\_\_\_\_

**Provider EFT Contact Information**

Provider Contact Name \_\_\_\_\_

Telephone Number \_\_\_\_\_ Telephone Number Extension \_\_\_\_\_

Email Address \_\_\_\_\_

**FINANCIAL INSTITUTION INFORMATION**

Financial Institution Name \_\_\_\_\_

Financial Institution Address \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_

Zip Code/Postal Code \_\_\_\_\_

Financial Institution Routing Number \_\_\_\_\_

Type of Account at Financial Institution (select one)  Checking  Savings

Provider's Account Number with Financial Institution \_\_\_\_\_

Account Number Linkage to Provider Identifier (select one)

Provider Tax Identification Number (TIN)

National Provider Identifier (NPI)

**REASON FOR SUBMISSION:**  New Enrollment  Change Enrollment  Cancel Enrollment

By signing this form, I authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to the checking or savings account indicated above at the financial institution identified above. Credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the Department of Health and Human Services to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws. I certify that the information shown is correct and agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

**All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.**

Written Signature of Person Submitting Enrollment \_\_\_\_\_

Printed Name of Person Submitting Enrollment \_\_\_\_\_

Submission Date \_\_\_\_\_

TO PROCESS YOUR EFT ENROLLMENT OR CHANGE EXISTING INFORMATION, PLEASE RETURN THIS COMPLETED FORM ALONG WITH VERIFICATION OF YOUR ELECTRONIC DEPOSIT INFORMATION ON YOUR FINANCIAL INSTITUTION'S LETTERHEAD TO:

Department of Health and Human Services  
Medicaid Provider Enrollment  
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809  
FAX (803) 870-9022

**SPECIAL INSTRUCTIONS:** For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider web page for instructions on how to complete updates to your EFT information.  
Effective January 01, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDHHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching trace number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.

**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<br>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: \_\_\_\_\_



# HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> <input type="checkbox"/> PICA <span style="float: right;">PICA <input type="checkbox"/></span>									
1. MEDICARE <input type="checkbox"/> (Medicare#)            MEDICAID <input type="checkbox"/> (Medicaid#)            TRICARE <input type="checkbox"/> (ID#DoD#)            CHAMPVA <input type="checkbox"/> (Member ID#)            GROUP HEALTH PLAN <input type="checkbox"/> (ID#)            FECA BENEFIT <input type="checkbox"/> (ID#)            OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE    SEX MM DD YY    M <input type="checkbox"/> F <input type="checkbox"/>				
5. PATIENT'S ADDRESS (No., Street)  CITY    STATE  ZIP CODE    TELEPHONE (Include Area Code) ( )					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)				
a. OTHER INSURED'S POLICY OR GROUP NUMBER  b. RESERVED FOR NUCC USE  c. RESERVED FOR NUCC USE  d. INSURANCE PLAN NAME OR PROGRAM NAME					11. INSURED'S POLICY GROUP OR FECA NUMBER  a. INSURED'S DATE OF BIRTH    SEX MM DD YY    M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC)  c. INSURANCE PLAN NAME OR PROGRAM NAME  d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, complete items 9, 9a, and 9d.				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)    15. OTHER DATE MM DD YY    QUAL.    MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  17a. _____ 17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB?    \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)    ICD Ind. _____ A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____									
24. A. DATE(S) OF SERVICE    B. PLACE OF SERVICE    C. EMG    D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)    E. DIAGNOSIS POINTER From MM DD YY To MM DD YY					F. \$ CHARGES    G. DAYS OR UNITS    H. EPDT Family Plan    I. ID. QUAL.    J. RENDERING PROVIDER ID. #				
1    2    3    4    5    6					22. RESUBMISSION CODE    ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER				
25. FEDERAL TAX I.D. NUMBER    88N EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.    27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				
28. TOTAL CHARGE \$ _____					29. AMOUNT PAID \$ _____				
30. Reserved for NUCC Use					31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  SIGNED _____ DATE _____				
32. SERVICE FACILITY LOCATION INFORMATION  a. NPI    b. _____					33. BILLING PROVIDER INFO & PH # ( )  a. NPI    b. _____				

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

# Sample Remittance Advice (page 1)

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

PROVIDER ID.			PROFESSIONAL SERVICES			PAYMENT DATE			PAGE								
AB00080000	DEPT OF HEALTH AND HUMAN SERVICES		REMITTANCE ADVICE		02/14/2014				1								
SOUTH CAROLINA MEDICAID PROGRAM																	
PROVIDERS	CLAIM		SERVICE RENDERED	AMOUNT	TITLE 19	S	RECIPIENT	RECIPIENT NAME	M	TLE. 18	COPAY	TITLE					
OWN REF.	REFERENCE		DATE (S)	BILLED	PAYMENT	T	ID.	F M	O	ALLOWED	AMT	18					
NUMBER	NUMBER	PY IND	MMDDYY	PROC.	MEDICAID	S	NUMBER	I I LAST NAME	D	CHARGES		PAYMENT					
ABB1AA	1403004803012700A		101713	71010	27.00	6.72	P	1112233333	M								
	01				27.00	6.72	P			026	0.00	0.00					
ABB2AA	1403004804012700A		101713	74176	259.00	0.00	S	1112233333	M								
	01				259.00	0.00	S			026	0.00	0.00					
ABB3AA	1403004805012700A		071913	A5120	24.00	0.00	R	1112233333	M								
	01				12.00	0.00	R			000		0.00					
	02		071913	A4927	12.00	0.00	R			000		0.00					
										Edits: L00 946 L02 852 08/30/13							
TOTALS											3	310.00				0.00	0.00
										\$6.72							
CERT. PG TOT		MEDICAID PG TOT		STATUS CODES:		PROVIDER NAME AND ADDRESS		FOR AN EXPLANATION OF THE									
\$0.00		\$286.46		P = PAYMENT MADE		ABC HEALTH PROVIDER		ERROR CODES LISTED ON THIS									
				R = REJECTED				FORM REFER TO: "MEDICAID									
				S = IN PROCESS		PO BOX 000000		PROVIDER MANUAL".									
CERTIFIED AMT		MEDICAID TOTAL		E = ENCOUNTER		FLORENCE		SC 00000									
IF YOU STILL HAVE QUESTIONS																	
PHONE THE D.H.H.S. NUMBER																	
SPECIFIED FOR INQUIRY OF																	
CLAIMS IN THAT MANUAL.																	
						CHECK TOTAL		CHECK NUMBER									

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.

# Sample Remittance Advice (page 2)

PROVIDER ID.			PROFESSIONAL SERVICES			PAYMENT DATE	PAGE
AB00080000	DEPT OF HEALTH AND HUMAN SERVICES		REMITTANCE ADVICE		02/28/2014		1
SOUTH CAROLINA MEDICAID PROGRAM							
PROVIDERS	CLAIM	SERVICE RENDERED	AMOUNT	TITLE 19	RECIPIENT	RECIPIENT NAME	TITLE
OWN REF.	REFERENCE	DATE(S)	BILLED	PAYMENT	ID.	F M	18
NUMBER	NUMBER	PY IND MMDDYY	PROC.	MEDICAID	NUMBER	I I LAST NAME	18
ABB222222	1405200415812200A			1192.00	243.71	P1112233333	M CLARK
	01	021814	S0315	800.00	117.71	P	0.00
	02	021814	S9445	392.00	126.00	P	0.00
VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018							
ABB222222	1405200077700000U			1412.00	273.71	P1112233333	M CLARK
	01	100213	S0315	1112.00	143.71	P	0.00
	02	100213	S9445	300.00	130.00	P	0.00
REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018							
ABB222222	1405200414812200A			1001.50	42.75	P1112233333	M CLARK
	01	100213	S0315	142.50	42.75	P	0.00
	02	100313	S9445	859.00	0.00	R	0.00
							0.00
							0.00
\$286.46							
CERT. PG TOT	MEDICAID PG TOT	STATUS CODES:		PROVIDER NAME AND ADDRESS		FOR AN EXPLANATION OF THE	
		P = PAYMENT MADE		ABC HEALTH PROVIDER		ERROR CODES LISTED ON THIS	
FORM REFER TO:	"MEDICAID	\$0.00	\$286.46	R = REJECTED			
PROVIDER MANUAL".		CERTIFIED AMT	MEDICAID TOTAL	S = IN PROCESS	PO BOX 000000		
				E = ENCOUNTER	FLORENCE	SC 00000	
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		

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

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

# Sample Remittance Advice (page 3)

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I I	M O D	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-						

  

PROVIDER	DEBIT BALANCE	MEDICAID TOTAL	CERTIFIED AMT	TO BE REFUNDED IN THE FUTURE
INCENTIVE AMOUNT	PRIOR TO THIS REMITTANCE	\$243.71	0.00	0.00
0.00	0.00			0.00
	ADJUSTMENTS			
\$193.71-				
CHECK TOTAL	CHECK NUMBER			
\$50.00	4197304			

  

PROVIDER NAME AND ADDRESS YOUR CURRENT DEBIT BALANCE	+	-	+	-
ABC HEALTH PROVIDER				
PO BOX 000000				
FLORENCE SC 00000				
		0.00		

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.

# Sample Remittance Advice (page 4)

PROVIDER ID.	+-----+	PAYMENT DATE	+-----+	PAGE
DEPT OF HEALTH AND HUMAN SERVICES	ADJUSTMENTS	02/28/2014	+-----+	3
AB11110000				
SOUTH CAROLINA MEDICAID PROGRAM				

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I I	ORIG. F M 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

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



**Please return signed original Attestation to:**

**Mailing Address:**

SC Dept. of Health and Human Services c/o  
 Division of Family Services  
 Post Office Box 8206  
 Columbia, South Carolina 29202-8206

**Fax: (803) 255-8204**

**Section I: Demographic Information**

Please Print:

<b>Physician or APRN Name</b>	
<b>Address:</b>	
<b>Facility:</b>	
<b>Telephone:</b>	
<b>National Provider Identifier Number (NPI)</b>	
<b>Fax:</b>	
<b>Email:</b>	

**Section II: Allied Professional Update Form**

The Allied Professional(s) 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 FQHC or RHC Standard. All allied professionals must be listed and a maximum of three allied professionals are permitted. Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage and Family Therapist

<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	
<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	
<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	

If there are any changes to this list, i.e. the allied professional's qualifications, physician or APRN information, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply shall result in the recoupment for services rendered. My signature and signature date certifies, that the information provided in the Attestation is correct.

\_\_\_\_\_ Physician or APRN Signature  
Date \_\_\_\_\_

Allied Professional Registration Form (Revised 4/2017)



Please return signed original Attestation to:

**Mailing Address:**

SC Dept. of Health and Human Services c/o  
 Division of Family Services  
 Post Office Box 8206  
 Columbia, South Carolina 29202-8206

Fax: (803) 255-8204

**Section I: Demographic Information**

Please Print:

<b>LISW-CP Name</b>	
<b>Address:</b>	
<b>Facility:</b>	
<b>Telephone:</b>	
<b>National Provider Identifier Number (NPI)</b>	
<b>Fax:</b>	
<b>Email:</b>	

**Section II: Allied Professional LMSW Update Form**

The Allied Professional(s) LMSW listed below are under my LISW-CP (licensed Independent social worker-clinical practice) supervision and services rendered and billed to South Carolina Medicaid will be in compliance with the guidelines as provided in the South Carolina Medicaid FQHC or RHC Standard. All allied professional(s) LMSW must be listed and a maximum of three LMSW(s) are permitted to be supervised by the LISW-CP. Licensed Master Social Worker (LMSW)

<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	
<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	
<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	

If there are any changes to this list, i.e. the allied professional’s qualifications, LISW-CP information, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply shall result in the recoupment for services rendered. My signature and signature date certifies, that the information provided in the Attestation is correct.

LISW-CP Signature

Date

LMSW Registration Form (Revised 4/2017)

South Carolina
Department of Health and Human Services
Mental Health Form

FILL OUT COMPLETELY TO AVOID DELAYS

Beneficiary's Name, Medicaid ID #, Date of Birth, Individual NPI, Organization NPI, Center's Name, 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)

Table with 6 columns: Symptom (e.g., Aggression, Depression), Scale (0-4), and Symptom (e.g., Side Effects, Sleep Disturbance).

Services

90833 90846 90853 90837
90836 90847 90832 H0002 90838 96101 90834

Current Medications table with columns: Name, Dose, Frequency, Side Effects. Includes compliance levels: >90%, 50-90%, <50%.

Reasons for Noncompliance:

Physician/Non physician Practitioner's Name

( ) Phone: ( ) Fax

physician Practitioner's Signature Date

Physician/Non

**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

DHHS Mental Health Form-(Revised 04/2013)

## 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





**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:

<b>Supervising Clinician Name:</b>	
<b>Address:</b>	
<b>Telephone:</b>	
<b>National Provider Identifier Number (NPI)</b>	
<b>Fax:</b>	
<b>Email:</b>	

**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

<b>LMSW Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	
<b>LMSW Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	
<b>LMSW Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	

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

# 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<br>Fax: 877-285-3226 | <input type="checkbox"/> BlueChoice HealthPlan Medicaid<br>Fax: 855-580-2810 | <input type="checkbox"/> Molina<br>Fax: 866-423-3889                   | <input type="checkbox"/> Wellcare<br>Fax: 866-455-6562   |
| <input type="checkbox"/> Advicare<br>Fax: 888-781-4316            | <input type="checkbox"/> First Choice by Select Health<br>Fax: 866-533-5493  | <input type="checkbox"/> SCDHHS (Fee-For-Service)<br>Fax: 803-255-8247 | <input type="checkbox"/> BlueCross BlueShield of South Carolina & BlueChoice HealthPlan<br>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			
<b>Parents</b> Did any of your parents have a problem with alcohol or drug use?	<input type="radio"/> YES		<input type="radio"/> NO
<b>Peers</b> Do any of your friends have a problem with alcohol or other drug use?	<input type="radio"/> YES		<input type="radio"/> NO
<b>Partner</b> Does your partner have a problem with alcohol or other drug use?		<input type="radio"/> YES	<input type="radio"/> NO
<b>Violence</b> Are you feeling at all unsafe in any way in your relationship with your current partner?	<input type="radio"/> YES		<input type="radio"/> NO
<b>Emotional Health</b> 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
<b>Past</b> 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
<b>Present</b> 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
<b>Smoking</b> Have you smoked any cigarettes in the past three months?		<input type="radio"/> YES	<input type="radio"/> NO
<b>Please provide additional details for any "yes" responses:</b>		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

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><b>Follow-up Arranged or Provided by Consultant:</b></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><b>Other Care Needed:</b></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 \_\_\_\_\_