

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 Denial with NPI	02/2012
CMS-1500 (02/12)	Sample Claim Showing TPL Denial with NPI and Medicaid Provider ID	02/2012
	Sample Remittance Advice	04/2014
	CMH Exceptions Fax Cover Sheet	06/2018
	Request for Service Limit Exception—Community Mental Health Centers	06/2018
	Corrective Action Plan	05/2021
	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, 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:

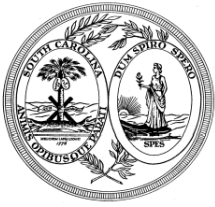
7. **Patient/Service Identification:**

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



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

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

Contact Person: _____ Phone #: _____ Date: _____

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

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

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

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

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

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

Fax:
803-252-0870

or

Mail:
Post Office Box 101110
Columbia, SC 29211-9804



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION**

PROVIDER _____ **DOS** _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

(SIGNATURE AND DATE)

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

**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)

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Ambulance Services <input type="checkbox"/> Autism Spectrum Disorder (ASD) Services <input type="checkbox"/> Clinic Services <input type="checkbox"/> Community Long Term Care (CLTC) <input type="checkbox"/> Community Mental Health Services <input type="checkbox"/> Department of Disabilities and Special Needs (DDSN) Waivers <input type="checkbox"/> Durable Medical Equipment (DME) <input type="checkbox"/> Early Intervention Services <input type="checkbox"/> Enhanced Services <input type="checkbox"/> Federally Qualified Health Center (FQHC) <input type="checkbox"/> Home Health Services <input type="checkbox"/> Hospice Services <input type="checkbox"/> Hospital Services | <ul style="list-style-type: none"> <input type="checkbox"/> Licensed Independent Practitioner’s Rehabilitative Services (LIPS) <input type="checkbox"/> Local Education Agencies (LEA) <input type="checkbox"/> Medically Complex Children’s (MCC) Waivers <input type="checkbox"/> Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) <input type="checkbox"/> Optional State Supplementation (OSS) <input type="checkbox"/> Pharmacy Services <input type="checkbox"/> Physicians Laboratories, and Other Medical Professionals Specify: _____ <input type="checkbox"/> Private Rehabilitative Therapy and Audiological Services <input type="checkbox"/> Psychiatric Hospital Services <input type="checkbox"/> Rehabilitative Behavioral Health Services (RBHS) <input type="checkbox"/> Rural Health Clinic (RHC) <input type="checkbox"/> Targeted Case Management (TCM) <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 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																							
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890																																							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John A.										3. PATIENT'S BIRTH DATE MM DD YY 01 01 1947					SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>																																		
5. PATIENT'S ADDRESS (No., Street) 123 Windy Lane										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																							
CITY Anytown					STATE SC					7. INSURED'S ADDRESS (No., Street)					8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>																																		
ZIP CODE 29999					TELEPHONE (Include Area Code) ()					CITY					STATE																																		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER 22222222B																													
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																													
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										b. EMPLOYER'S NAME OR SCHOOL NAME 0.00																													
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME 401																													
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE 1										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED																													
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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. <input type="checkbox"/> <input checked="" type="checkbox"/> NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																													
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 295 32																				23. PRIOR AUTHORIZATION NUMBER																													
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY					B. PLACE OF SERVICE					C. EMG					D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER					E. DIAGNOSIS POINTER					F. \$ CHARGES					G. DAYS OR UNITS					H. EPSDT Family Plan					I. ID. QUAL.					J. RENDERING PROVIDER ID. #				
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25. FEDERAL TAX I.D. NUMBER 55555555										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. DOE1234					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 10200					29. AMOUNT PAID \$ 000					30. BALANCE DUE \$ 10200														
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.)										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.										33. BILLING PROVIDER INFO & PH # (555) 5555555 Local Community Mental Health Center 111 Main Street Anytown, SC 22222-2222																													
SIGNED DATE										a. 1234567890 b. ZZ1212121212																																							

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																																																									
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b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										b. EMPLOYER'S NAME OR SCHOOL NAME 0.00																																																																															
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME 401																																																																															
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE 1										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																																																															
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25. FEDERAL TAX I.D. NUMBER 55555555										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. DOE1234										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 10200										29. AMOUNT PAID \$ 000										30. BALANCE DUE \$ 10200																																							
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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Only

Sample Remittance Advice (page 1)

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

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

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".	CERT. PG TOT \$0.00	MEDICAID PG TOT \$286.46	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
IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.	CERTIFIED AMT 0.00	MEDICAID TOTAL 0.00	CHECK TOTAL	CHECK NUMBER

Please note that the procedure codes and payment amounts used in these samples are examples only. They are not the actual charge amounts for the services listed.

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.					ADJUSTMENTS	PAYMENT DATE	PAGE
AB11110000	DEPT OF HEALTH AND HUMAN SERVICES					02/28/2014	3
	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

PROVDER 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

Please note that the procedure codes and payment amounts used in these samples are examples only. They are not the actual charge amounts for the services listed.

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

FAX COVER SHEET

CONFIDENTIAL INFORMATION ENCLOSED

DATE: _____

TO: SCDHHS – Division of Behavioral Health

Attn: CMHC Exceptions

Fax # 803-255-8204

FROM: _____

Telephone #: _____

Contact Person: _____

Total Number of Pages Transmitted: _____ (Including Cover Sheet)

COMMENTS:

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, or the employee or agent responsible to deliver it to 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 and destroy the related message. Thank you.

Behavioral Health Services
P.O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2565 Fax (803) 255-8204



Henry McMaster GOVERNOR
 Joshua D. Baker DIRECTOR
 P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Request for Service Limit Exception—Community Mental Health Centers

Beneficiary Information	
Name:	
Address:	
Medicaid ID #:	
Date of Birth:	

Provider Information	
Provider Name:	
Provider NPI:	
Address:	
City / State / Zip Code	
Phone Number	
Fax Number	

Diagnosis - Code / Description:	/
Diagnosis - Code / Description:	/
Diagnosis - Code / Description:	/

Clinical Rationale for Request

Services Requested			
Procedure Code	Service Name	# of Units Currently Authorized (If applicable)	# of Additional Units Requested

LPHA or QMHP Name: _____

Credentials: _____

Signature: _____

Date: _____

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

The Division of Behavioral Health Corrective Action Plan

Provider Name			
Contact Person		Phone Number	
Contact Email		Fax Number	
Date Submitted to SCDHHS			

Item # on Summary	Opportunity for Improvement	Corrective Action Steps to be Implemented	Person(s) Responsible for Implementation	Target Date to Implement Corrective Action	Completion Date for Implementation
1					
2					
3					
4					
5					

Additional questions to be addressed:

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.**

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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: