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:

Provider ID:

NPI:

Recipient ID:

Adjustment Type:

Q Void Q Void/Replace

Originator:

Q DHHS Q MCCS Q Provider Q MIVS

Reason For Adjustment: (Fill One Only)

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

For Agency Use Only

Analyst ID:

- O Hospital/Office Visit included in Surgical Package
- O Independent lab should be paid for service
- O Assistant surgeon paid as primary surgeon
- O Multiple surgery claims submitted for the same DOS
- O MMIS claims processing error
- O Rate change
- O Web Tool error
- O Reference File error
- O MCCS processing error
- O 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'sName/Address: _____

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

a. beneficiary has never been covered by the policy - close insurance.

b. beneficiary coverage ended-terminate coverage (date) _____

c. subscriber coverage lapsed - terminate coverage (date) _____

d. subscriber changed plans under employer - new carrier is _____

new policy number is _____

e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

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

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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER_____ **DOS** _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

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

_____

(SIGNATURE AND DATE)

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

Revised 04/2014

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# _____ (characters)

   NPI#_____ Taxonomy _____

3. Person to Contact:_____ Telephone Number:_____

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

   _____
   _____
   _____
   _____
   _____

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

5. street Address for delivery of request:

   street: _____

   City: _____

   State _____

   Zip Code: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

6. Charges for duplicate remittance advice(s) are as follows:

   Request Processing Fee - $20.00

   Page(s) copied - .20 per page

I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.

_____ _____
Authorizing Signature Date

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Healthy Connections MEDICAID

Submit your Claim Reconsideration request to:

Fax: 1-855-563-7086

or

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

CLAIM RECONSIDERATION FORM

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

Section 1: Beneficiary Information

Name (Last, First,MI): _____

Date of Birth: _____ Medicaid Beneficiary ID: _____

Section 2: Provider Information

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

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

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

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

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

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

Section 4: Claim Reconsideration Information

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

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

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____ Date: _____

ff

HEALTH INSURANCE CLAIM FORM

APPROVED If/f NATIONALUNIFORM CUJMCOMMITTEE (NUCC) 02/12

Community Mental Health Services
Sample Claim Showing TPL Denial
withNPI

7T7 PICA

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PICA

1. MEDICARE MEDIGNB TRIGARE

7) I&](Modb/dl} (IDIM]aDII/

2. PATIENl'SNAME (LatNomo, FIrotNuno, Mlddlo InIIlol)

a. PATIENT'S BIRTH DATE BEX

RED'SNAME (Lat Nomo FIrotNuno)

TELEPHONE (Include Area Code)

( )

Doe,JohnA.

i I 0°f I 191 7 MOO

7. INSUREDS ADDFEBS (No /

5. PA TIENrSADDRESS (No., BlrN1)

123 Windy Lane

e. PATIENT RELATIOHSHIPTOINSURED

BeN 8 poLB8 Chtl 011or

CITY STATE 8. RESERVED FORNUCC USE CIIY

11ldcp, IMCOOES (DNIIJ; CC)

d, IS THERE ANOTHER HEALTHBE PLAN

19. ADDITIO ATION (Designated by NUCC)

8. OTHER INSURED'S NAME (Lat-- FIrelNamo, Mlddlo InIIlol)

10. ISPATIENT'S CONDmONREIATEDTO<

11. INSURED'SPOLICYGROUPORFI:CANU{M EJI

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Anytown | SC

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:: D Signature on File ... DATE SIGNED

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555555555 ☐18J	DOE1234	S 102:00 S O:OO 102:00
31. SIGNATURE OFPHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIAJ..8 (I conlfy thot IIIe atalamonll on IIIe apply1D this bil Ind aN ,__ •part• ,)	32. SERVICE FACILITY LOCATION INFORMATIDN	3". BIW NG PROVIDERINFO &PHO (555) 5555555 Local CMH Center 11 Main Street Anytown, SC 22222-2222
SIGN ED DATE	▪ ▪	L 1234567890 b. ZZ1212121212

I-.R ESE=RV=ED=RU=cc=sLE ---------- j c. OTHE [&] NO 0 19 0 DENT? -:1 NB

d. INSURANCE**PLAN NAME** ORPROGRAM NAME

D YES 0 NO

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12. PATIENT'SORAUTHORIZED PERS0"5 SIGNATURt: I•- 1ho-0l II!IYnNloal o, odll ,y payment olmodJc:oj bonafIto lo 1110 od phyo"-'oroupplIorfcr

1op,...,..1Hodun . l_, n,q.- .-ymontofg--,,m ,. ...,...,_...,_,,. .,,,,...arlo 1ho- \. .....,a.. Nfwlooo_bod_.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY 15. OTHER DATE 18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

I I DUAL , ... QUAL : FROM I TO I I

20. OUTIIIDELAS? 8CHARGEB

D YES 0 No I I

2,2 [!6 ISSION I 0RIGINALREF.NO.

QUAL - PROVIDERID. f -------,

17. NAMEOf REFERRINGPI!OfDER ERSOURCE 1 1 I _____,1a.HOSPriiQljv:n8tj DATEYBELATEDTOCI.J! NT&,ERYIC

FROM TO

23. PRIORAUTHORIZATIONNUMBER

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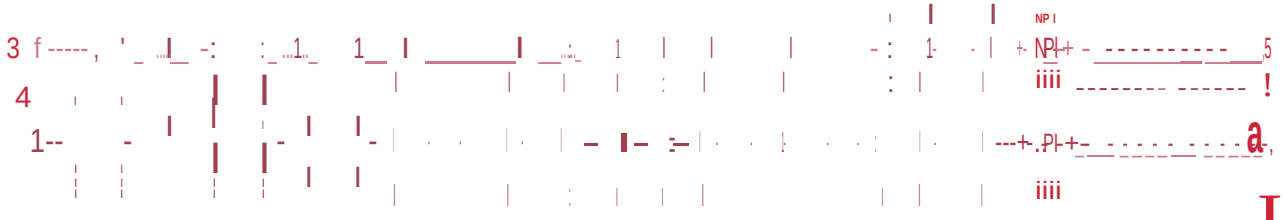

Community Mental Health Services
Sample Claim Showing TPL Denial
withNPI and Medicaid Provider ID

HEALTHINSURANCE CLAIM FORM

APP R OVEDBY NATIONALUNIFORMCLAIMCOMMITTEE (NUCC) 02/12

1 M MEDICAID TAICARE CHAMPVA PLAN LI.NG 01HaR 1a I NSURED'S D N UMBER (F otP ragrom ir,: : 1)
(Mlld<M&#) I&] (Mld:&'dl) (IOillQIO#) DB I&] (dol} (/Of) 1/0lfJ 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Doe, John A.	MM DD YY 01 01 1947 M X F	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
123 Windy Lane	Self Spouse Child Other	
CITY STATE	8. REBERVED R>R NUCC USE	CITY STATE
Anytown SC		
ZIP CODE TELEPHONE Onoludo AniaC<m)		ZIP CODE TELEPHONE (Include Area Code)
29999		( )
9. OTI1ER INSURED'S NAME (Lalt Nmna, FIrwlNIfff8,MIcIdlo I nlllal)	10. IS PATIEI'lni CONDmON REIATEDTO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
		222222222222B
L OTHER INSURED'& POLICY OR GROUP NUMBER	• . EMPLOYMEPir? (Cumantor "9)	a. INSURED'S DATE OF BIRTH SEX
	DYES X NO	MM DD YY M F
b.RESERVED FOR NUCC USE	b . AIJTOACCIDENTY PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	DYES X NO	0 00
• · RESERVEDFOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	401
d. INSURANCEPLANNAME OR P ROGRAMNAME		
	1	YES DNO It, -. complolol8ml9. Ila,ard9d.

READBACKOFFORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'SOR AUlliORIZED PERSON'SSIGNATURIa authorize the release of any medical or other information necessary taP"""""tHadun .l _, n,q.-,-ym,nl of g,-n m•nt bin benefits either to myself or to the party who accepts assignment below.

S IG NED Sign ature on Fil e DATE

13. INSURED'SOR AUTHORIZED PERSOtfS SIGNATUREI authortza pay.- loal benellta lo "10 od pt,yolclanor oupplforfor

SIGNED

14. DATE OF CURAENT MM 1 00 , VY	II. NESSINJURY, or PREGNANCY (LMP)	15. OTHER DATE QUAL. MM DD YY	1B.DAIEBPATIENTUNABI.ETO WORKIN CURRENT OCCUPATION MM 1 DD 1 VY FROM TO MM 1 DD 1 YY
17. NAMEOF REFERRING PROVIDER	OR OTHER SOURCE	17a.	18. H OSPIT TI °;" TEWEIAm> TOCIf :" VIC FROM TO
		17b. NPI	

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OOTBIDE LAB? &CHARGES
DYES 0 No

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. (!!&. ISED ORGINARERNO
A. 295 32 B. C. a D. H. MEDICAIRIZATI=ONUM BER
E. F.
I. J. K. L.

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. D PROCEDURES,SERVICESOR BUPPUES (EIll>laInUnuauaJClrcu11'B1811C81) EMli CPTIHCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. IIAIll 0R LNUU	H.	I. ID. QUAL.	J. RENDERING PROVIDERID. f
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2									NPI	
3									NPI	
4									NPI	
5									N P I	
6									NPI	

25.FEDERALTAX I.D. NUMBER SBN EIN	28. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For gov. claims, see back)	211. TIJTAL CHARGE	211. AMO UNT PA ID	30 . IbMIltr NUCCU•
555555555	D OE1234	X YES NO	S 102200	S 0.00	102 100

31. S IGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES ORCAEDENTIALS (I c:1111fY1111111ho lfalemonll! onlha.....,,. apply101hil bil orwlara .-a part- .)	32. SERVICE FACIIJTY LOCATION INFORMATION	33. BIW NG PROVIDERINR> & PH 0 555 5555555
SIGNED DATE	a. b.	Local CMH Center 11 Main Street Anytown, SC 22222-2222 L 1234567890 1DABC123

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

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT	MEDICAID PG TOT
$0.00	$286.46
CERTIFIED AMT	MEDICAID TOTAL
	0.00
	CHECK TOTAL

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

CHECK NUMBER

PROVIDER NAME AND ADDRESS

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.

Sample Remittance Advice (page 2)

This page of the sample Remittance Advice shows a paid claim, as well as a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle.

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

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	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
ABB222222	1405200415812200A				1192.00	243.71	P	1112233333	M CLARK			0.00	
	01		021814	S0315	800.00	117.71	P			000			0.00
	02		021814	S9445	392.00	126.00	P			000			0.00
	VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018												
ABB222222	1405200077700000U				1412.00-	273.71-	P	1112233333	M CLARK				
	01		100213	S0315	1112.00-	143.71-	P			000			
	02		100213	S9445	300.00-	130.00-	P			000			
	REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018												
ABB222222	1405200414812200A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		100213	S0315	142.50	42.75	P			000			0.00
	02		100313	S9445	859.00	0.00	R			000			0.00
												0.00	0.00
						$286.46							

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT	MEDICAID PG TOT
$0.00	$286.46

CERTIFIED AMT	MEDICAID TOTAL
	0.00

CHECK TOTAL

CHECK NUMBER

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

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

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 3)

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

PROVIDER ID. AB11110000

DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE 02/28/2014

PAGE 2

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

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	0.00

ADJUSTMENTS		PROVIDER NAME AND ADDRESS
$193.71-		ABC HEALTH PROVIDER
YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PO BOX 000000
0.00	$50.00	4197304	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.

Sample Remittance Advice (page 4)

This page of the sample Remittance Advice shows four gross-level adjustments.
Gross-level adjustments always appear on the final page of the Remittance Advice.

PROVIDER ID.: AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE: 02/28/2014

PAGE: 3

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

PROVDER INCENTIVE CREDIT AMOUNT: 0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: 0.00

ADJUSTMENTS: -4338.95

CHECK TOTAL: 0.00

CERTIFIED AMT: 0.00

CHECK NUMBER:

0.00

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

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.

SOUTH CAROLINADEPARTMENT OF HEALTH ANO HUMAN SEIMCES
Healthy Connections
M EDICAID, .

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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID,

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**	**# *af* Units Currenlty Authorized(If aoolicable)**	**# *af* Additional Units Requested**

LPHAo r QMHP Name: _____

ed iln :t _____

Sgi na tur e: _____

Date: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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)** ☐ Prior Authorization ☐ 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:** ☐ Male ☐ Female
8. **a. NPI/Requesting Service Provider Name & ID Number:** **b. 9-digit Zip Code (Mandatory)**	9. **Treatment Setting** ☐ 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:** ☐ LAB	**CPT CODE:** ☐ 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.

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 **X** 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 **X** 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.**