

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
	Electronic Funds Transfer (EFT) Authorization Agreement	08/2019
	Duplicate Remittance Advice Request Form	09/2017
	Claim Reconsideration Form	11/2018
CMS-1500 (02/12)	Sample Claim Showing Medicaid and Medicare with NPI	02/2012
CMS-1500 (02/12)	Sample Claim Showing Medicaid Only with NPI	02/2012
CMS-1500 (02/12)	Sample Claim Showing Medicaid and Private Pay with NPI and Medicaid Provider ID	02/2012
CMS-1500 (02/12)	Sample Claim Showing Medicare, Medicaid, Private Pay with NPI and Medicaid Provider ID	02/2012
	Sample Remittance Advice	04/2014
DME 001	Medicaid Certificate of Medical Necessity Equipment/Supplies	04/2018
DME 003	Medicaid Certificate of Medical Necessity Power/Manual Wheelchairs and/or Accessories	04/2018
DME 004	Medicaid Certificate of Medical Necessity Orthotics, Prosthetics, and Diabetic Shoes	04/2018
DME 005	Medicaid Certificate of Medical Necessity Enteral Nutrition	04/2018
DME 006	Medicaid Certificate of Medical Necessity Parenteral Nutrition	04/2018
DME 007	Medicaid Certificate of Medical Necessity Oxygen	04/2018
DME 008	Certificate of Repair and Labor Cost	02/2010

FORMS

Number	Name	Revision Date
	Justification for Home Uterine Activity Monitor/Supplies (HUAM) for Subcutaneous Tocolytic Therapy	02/2013



**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 (12 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
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.**

REASON FOR SUBMISSION											
<input type="checkbox"/> Change to Current EFT (i.e. account or bank changes) <input type="radio"/> Individual <input type="radio"/> Organization											
INDIVIDUAL PROVIDER/ORGANIZATION INFORMATION											
Individual Provider/Organization Legal Business Name											
Doing Business as Name (DBA)											
Street											
City				State		Zip Code/Postal Code				-	
Medicaid Provider Number				National Provider Identifier (NPI)							
Designate Tax Identification Number (TIN)				<input type="radio"/> SSN (individual)				<input type="radio"/> EIN (organization)			
SSN				EIN				-			
ORGANIZATION/INDIVIDUAL PROVIDER EFT CONTACT INFORMATION											
Provider Contact Name											
Telephone Number								Extension			
Email Address											
FINANCIAL INSTITUTION INFORMATION											
Financial Institution Name											
Financial Institution Address											
City				State		Zip Code/Postal Code				-	
PROVIDER'S ACCOUNT NUMBER WITH FINANCIAL INSTITUTION											
Financial Institution Routing Number (Nine digits)											
Provider's Account Number with Financial Institution (Up to 17 digits)											
Type of Account at Financial Institution (TRANSIT CODE)				<input type="radio"/> 22 – Checking Account or <input type="radio"/> 32 – Savings Account							

By signing this form, I authorize the SCDHHS to initiate credit entries, if necessary, debit entries for any credits in error to the checking or savings account at the financial institution identified above. Credit entries will pertain only to the SCDHHS payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the SCDHHS 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 30 days written notice to the address shown below prior to revoking or revising this authorization.

I acknowledge that I have read and understand that payments will be issued only to the bank account of the provider designated to receive payments beginning July 2019 with the transition of Medicaid claims payments to the South Carolina Enterprise Information System (SCEIS). For more information, please visit <https://vip.scdhhs.gov/sceis> or contact 888-289-0709.

ALL EFT REQUESTS ARE SUBJECT TO A 10-DAY PRENOTE PERIOD IN WHICH ALL ACCOUNTS ARE VERIFIED BY THE QUALIFYING FINANCIAL INSTITUTION BEFORE ANY MEDICAID DIRECT DEPOSITS ARE MADE.

Signature of Person Submitting Form (print to sign)											
Printed Name of Person Submitting Form											
Submission Date											

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT update, please contact the Provider Service Center at 888-289-0709. Please refer to the EFT section of the provider enrollment manual found at <https://www.scdhhs.gov/provider> for instructions on how to complete updates to your EFT information.

Effective Jan 01, 2014, providers can link their EFT with their electronic remittance advice (ERA) by a matching EFT Reassociation Trace Number. This trace number will automatically be included in your electronic remittance advice. In order for this trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding the EFT Reassociation Trace Number and ERA can be directed to the Provider Service Center at 888-289-0709.

To process **EFT updates**, please return this completed form along with verification of your electronic deposit information on your financial institution's letterhead to:

SCDHHS, Medicaid Provider Enrollment • PO BOX 8809 • Columbia, South Carolina 29202-8809 • FAX 803-870-9022

**South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form**

Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact the SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us> for instructions on submission of your request.

1. Provider Name: _____
2. Medicaid Legacy Provider # _____ (Six Characters)
NPI# _____ Taxonomy _____
3. Person to Contact: _____ Telephone Number: _____
4. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:

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

5. Street Address for delivery of request:
Street: _____
City: _____
State: _____
Zip Code: _____
6. Charges for duplicate remittance advice(s) are as follows:
Request Processing Fee - \$20.00
Page(s) copied - .20 per page

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

Authorizing Signature

Date

Submit your Claim Reconsideration request to:

Fax: 1-855-563-7086

or

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

CLAIM RECONSIDERATION FORM

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

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ Medicaid Beneficiary ID: _____

Section 2: Provider Information

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

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

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

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

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

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

Section 4: Claim Reconsideration Information

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

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

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____

Date: _____



HEALTH INSURANCE CLAIM FORM

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

Durable Medical Equipment
Sample Claim Showing Medicaid Only
With NPI

CARRIER

<input type="checkbox"/> PICA <input type="checkbox"/> PICA																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#DoD#) (Member ID#) (ID#)</small>					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		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																						
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"/>		7. INSURED'S ADDRESS (No., Street)																						
CITY Anytown			STATE SC		8. RESERVED FOR NUCC USE			CITY STATE																					
ZIP CODE 29999		TELEPHONE (Include Area Code) ()			ZIP CODE		TELEPHONE (Include Area Code) ()																						
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																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																			
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)																			
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC) 1					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: 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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.					15. OTHER DATE MM DD YY QUAL.					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.					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY														
17b. NPI										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										22. RESUBMISSION CODE					ORIGINAL REF. NO.														
A. 846 0 B. C. D.										23. PRIOR AUTHORIZATION NUMBER																			
E. F. G. H.										24. A. DATE(S) OF SERVICE From MM DD YY To 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. FSD/ Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1 01 20 14 01 20 14 AA4253 00 90 00 2 ZZ 1212121212 NPI 1234567890										2					3														
3										4					5														
4										5					6														
5										6																			
6										25. FEDERAL TAX I.D. NUMBER 555555555 89N EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. DOE1234					27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 90 00 29. AMOUNT PAID \$ 0 00 30. Ruled for NUCC Use 90 00				
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					33. BILLING PROVIDER INFO & PH # (555) 555-5555 ABC Medical Supply 111 Main Street Anytown, SC 22222-2222														
SIGNED DATE										a. NPI					b. ZZ1212121212														

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



HEALTH INSURANCE CLAIM FORM

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

Durable Medical Equipment
Sample Claim Showing Medicaid and Private Pay
with NPI and Medicaid Provider ID

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA																													
1. MEDICARE <input checked="" type="checkbox"/> (Medicare#) MEDICAID <input checked="" type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										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"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
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"/>										7. INSURED'S ADDRESS (No., Street)																			
CITY Anytown					STATE SC					CITY					STATE																								
ZIP CODE 299999					TELEPHONE (Include Area Code) ()					ZIP CODE					TELEPHONE (Include Area Code) ()																								
8. 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 01200000A																			
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. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLAGE (State)										b. OTHER CLAIM ID (Designated by NUCC) 22 00																			
c. RESERVED FOR NUCC USE										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. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" 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 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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										15. OTHER DATE MM DD YY QUAL										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. 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? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										22. RESUBMISSION CODE ORIGINAL REF. NO.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.																				23. PRIOR AUTHORIZATION NUMBER																			
A. 846 0		B.		C.		D.		E.		F.		G.		H.		I.		J.																					
MM DD YY		MM DD YY		PLACE OF SERVICE		EMG		CPT/HCPCS		MODIFIER		DIAGNOSIS POINTER		\$ CHARGES		G. DAYS OR UNITS		H. EPIDIO Family Pay		I. ID. QUAL		J. RENDERING PROVIDER ID. #																	
01 20 14		01 20 14		12		A4253		00				90 00		2		NPI		1D		ABC123		1234567890																	
1																																							
2																																							
3																																							
4																																							
5																																							
6																																							
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 \$ 90 00					29. AMOUNT PAID \$ 22 00					30. Paid for NUCC Use 68 00									
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 ABC Medical Supply 111 Main Street Anytown, SC 22222-2222 a. 1234567890 b. 1DABC123																			



HEALTH INSURANCE CLAIM FORM

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

Durable Medical Equipment
Sample Claim Showing Medicare, Medicaid and
Private Pay with NPI and Medicaid Provider ID

<input type="checkbox"/> PICA <input type="checkbox"/> PICA										
1. MEDICARE <input checked="" type="checkbox"/> (Medicare#) MEDICAID <input checked="" type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK (LUNG) <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)					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 SEX 01 01 1947 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
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"/>		7. INSURED'S ADDRESS (No., Street)			
CITY Anytown			STATE SC		8. RESERVED FOR NUCC USE			CITY STATE		
ZIP CODE 299999			TELEPHONE (Include Area Code) ()		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:		
9a. OTHER INSURED'S POLICY OR GROUP NUMBER 012345678			9b. RESERVED FOR NUCC USE		9c. RESERVED FOR NUCC USE 50.00			9d. INSURANCE PLAN NAME OR PROGRAM NAME 620		
10a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					10b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLADE (State)		10c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10d. CLAIM CODES (Designated by NUCC)					11. INSURED'S POLICY GROUP OR FECA NUMBER 01200000A			11a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		
11b. OTHER CLAIM ID (Designated by NUCC) 0100					11c. INSURANCE PLAN NAME OR PROGRAM NAME 400			11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" 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 Signature on File DATE					SIGNED					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL					15. OTHER DATE MM DD YY QUAL					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. 17b. NPI					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										
A. 846.0 B. C. D. E. F. G. H. I. J. K. L.										
24. A. DATE(S) OF SERVICE From To PLACE OF SERVICE EMG CPT/HCPCS MODIFIER DIAGNOSIS POINTER					F. \$ CHARGES G. DAYS OR UNITS H. FROST Family Plan I. ID. QUAL J. REFERRING PROVIDER ID. #					
1 01 20 14 01 20 14 12 A4253 00					90.00 2 NPI 1234567890					
2					NPI					
3					NPI					
4					NPI					
5					NPI					
6					NPI					
25. FEDERAL TAX I.D. NUMBER 555555555			25b. SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. DOE1234		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 90.00	
28. AMOUNT PAID \$ 50.00			29. Ravel for NUCC Use 40.00		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 ABC Medical Supply 111 Main Street Anytown, SC 22222-2222					
SIGNED DATE					a. 1234567890 b. 1DABC123					

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1600 (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					
+-----+	DEPT OF HEALTH AND HUMAN SERVICES						+-----+	+-----+					
AB00080000	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 S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB1AA	1403004803012700A 01		101713	71010	27.00 27.00	6.72 6.72	P P	1112233333	M CLARK		026	0.00	0.00
ABB2AA	1403004804012700A 01		101713	74176	259.00 259.00	0.00 0.00	S S	1112233333	M CLARK		026	0.00	0.00
ABB3AA	1403004805012700A 01 02		071913 071913	A5120 A4927	24.00 12.00 12.00	0.00 0.00 0.00	R R R	1112233333	M CLARK		000 000	0.00	0.00 0.00
TOTALS			3		310.00				Edits: L00 946 L02 852 08/30/13			0.00	0.00
					\$6.72								
FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".			CERT. PG TOT	\$0.00	MEDICAID PG TOT	\$286.46	STATUS CODES:		PROVIDER NAME AND ADDRESS				
IF YOU STILL HAVE QUESTIONS+-----+			CERTIFIED AMT	0.00	MEDICAID TOTAL	0.00	P = PAYMENT MADE		ABC HEALTH PROVIDER				
PHONE THE D.H.H.S. NUMBER							R = REJECTED		PO BOX 000000				
SPECIFIED FOR INQUIRY OF +-----+							S = IN PROCESS		FLORENCE SC 00000				
CLAIMS IN THAT MANUAL.					CHECK TOTAL		E = ENCOUNTER						
							CHECK NUMBER						

Sample Remittance Advice (page 2)

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

PROVIDER ID.			PROFESSIONAL SERVICES			PAYMENT DATE	PAGE						
+-----+ AB00080000 +-----+	DEPT OF HEALTH AND HUMAN SERVICES		REMITTANCE ADVICE		+-----+ 02/28/2014 +-----+		+-----+ 1 +-----+						
SOUTH CAROLINA MEDICAID PROGRAM													
PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	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
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								
					CERT. PG TOT	MEDICAID PG TOT	STATUS CODES:		PROVIDER NAME AND ADDRESS				
FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".					\$0.00	\$286.46	P = PAYMENT MADE R = REJECTED S = IN PROCESS E = ENCOUNTER		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.						0.00							

Sample Remittance Advice (page 3)

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

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

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I	M F 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
		ADJUSTMENTS		
		\$193.71-		
	YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PROVIDER NAME AND ADDRESS
	0.00	\$50.00	4197304	ABC HEALTH PROVIDER PO BOX 000000 FLORENCE SC 00000

Sample Remittance Advice (page 4)

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

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

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

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

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR EQUIPMENT/SUPPLIES**

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

- (1) Recipient's name: _____ Medicaid # (10 digits): _____
- (2) DOB: ___/___/___ Sex: ___ HT: _____ (in) WT: _____ Date of Service: ___/___/___
- (3) Provider's name: _____ Provider's DME #: _____ NPI #: _____
- (4) Street address: _____ City: _____ State: ___ Zip: _____ Local telephone #: _____
- (5) Provider's signature: _____ Date: _____
- (6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT/SUPPLIES:

NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD) _____ Description(s): _____

(8) Indicate patient's ambulatory status while performing activities of daily living: ___Non-ambulatory ___Ambulatory, without assistance
___Ambulatory with the aid of a walker or cane, ___Ambulatory, with other assistance as described

Does the patient have decubitus ulcers? ___ Yes ___ No. If yes, circle stage(s): I, II, III, or IV. Indicate the wound size(s): _____

Please describe how this equipment / supply is medically necessary, the benefits to the recipient and how long will it take for the benefit to be evident:

(9) For supplies, please indicate the dressing change required per day, week, month, etc.

Is additional information attached on separate sheet? ___ Yes ___ No (If "yes," enter recipient's name & I.D. Medicaid number on attachment)

(10) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____

(11) Please indicate the prescription date: _____

(12) Duration of need (maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(13) PHYSICIAN'S NAME: _____ PHYSICIAN'S NPI #: _____

PHYSICIAN'S SIGNATURE _____ DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR EQUIPMENT/SUPPLIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

- RECIPIENT'S NAME AND MEDICAID #:** Indicate the patient's name and his/her Medicaid # (10 digits).
- PATIENT DOB, SEX, HEIGHT, WEIGHT:** Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.
- DATE OF SERVICE:** Indicate the date of service (DOS). The date of service must be the same as the delivery date.
- PROVIDER'S NAME, DME # AND NPI #:** Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.
- PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:** Indicate the provider's physical address (provider's location) and telephone number.
- PROVIDER SIGNATURE AND DATE:** Signature of DME provider representative and date.
- HCPCS CODES:** List all HCPCS procedure codes for items ordered by the treating/ordering physician.
Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

- DIAGNOSIS CODES:** In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).
- QUESTION SECTION:** These fields are used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.
- DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:** Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.
- PRESCRIPTION DATE:** Indicate the prescription date. The prescription date must be within 90 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.
- EST. LENGTH OF NEED:** Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.
- PHYSICIAN ATTESTATION:** The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.
- PHYSICIAN SIGNATURE AND DATE:** After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR POWER/MANUAL WHEELCHAIRS AND/OR ACCESSORIES**

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

- (1) Recipient's name: _____ Medicaid # (10 digits) _____
- (2) DOB ___/___/___ Sex: ___ HT: _____ (in) WT: _____ Date of Service: _____
- (3) Provider's name: _____ Provider's DME #: _____ NPI#: _____
- (4) Street address: _____ City: _____ State: _____ Zip: _____ Local telephone #: _____
- (5) Provider's signature: _____ Date: _____
- (6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN ON: _____

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

I ATTEST THAT THE PT/OT THERAPIST AND/OR THE TREATING /ORDERING PHYSICIAN HAS NO FINANCIAL RELATIONSHIP WITH MY COMPANY.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

- (7) Diagnosis codes (ICD): _____ Diagnosis(s): _____

- (8) Indicate the patient's mobility limitation & explain how it interferes with the performance of activities of daily living (ADLs):

 - Explain why a cane or walker is not sufficient to meet the patient's mobility needs in the home:
 - Explain why a manual wheelchair is not sufficient to meet the patient's mobility needs in the home:
 - How long has the condition been present and what is the patient's clinical progression:_____

 - Indicate any related diagnosis and all other interventions tried and the results:_____

 - Has the patient ever used a walker, manual or power wheelchair and what were the results?_____

- (9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____
- (10) Prescription Date: _____
- (11) Duration of need (Maximum of 12 months): _____

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

- (12) PRINT PHYSICIAN'S NAME: _____ PHYSICIAN'S NPI # _____
- PHYSICIAN'S SIGNATURE: _____ DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

**INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR POWER/MANUAL
WHEELCHAIRS AND/OR ACCESSORIES**

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #: Indicate the patient's name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.

DATE OF SERVICE: Indicate the date of service (DOS). The date of service must be the same as the delivery date.

PROVIDER'S NAME, DME # AND NPI#: Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.

PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER: Indicate the provider's physical address (provider's location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician.
Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).

QUESTION SECTION: This information is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.

DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.

PRESCRIPTION DATE: Indicate the prescription date. The prescription date must be within 90 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.

PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICAID CERTIFICATE OF
MEDICAL NECESSITY FORM FOR ORTHOTICS, PROSTHETICS AND DIABETIC SHOES**

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

- (1) Recipient's name: _____ Medicaid # (10 digits): _____
- (2) DOB: ____/____/____ Sex: ____ HT: _____ (in) WT: _____ Date of Service: _____
- (3) Provider's name: _____ Provider's DME #: _____ NPI #: _____
- (4) Street address: _____ City: _____ State: ____ Zip: _____ Local telephone #: _____
- (5) Provider's signature: _____ Date: _____
- (6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR ORTHOTICS, PROSTHETICS, AND/OR DIABETIC SHOES. _____

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

- (7) Diagnosis codes (ICD): _____ Diagnosis (s): _____
- _____
- _____
- (8) Give a detailed description of the severity of the recipient's condition(s) as related to orthotics, prosthetics, and/or diabetic shoes.
- Orthotics and/or Prosthetics:**
- _____
- _____
- Diabetic Shoes:** Does the patient have one or more of the following conditions? Check all that apply:
- ____ History of previous foot ulcerations ____ Peripheral neuropathy with evidence of callus formation ____ Foot deformity
- ____ Poor circulation ____ History of partial or complete amputation of the foot ____ History of pre-ulcerative callus
- Is additional information attached on a separate sheet? ____ Yes ____ No (If "yes," enter recipient's name and Medicaid I.D. number on attachment)
- (9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____
- (10) Prescription Date: _____
- (11) Duration of need (Maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

- (12) PRINT PHYSICIAN'S NAME: _____ PHYSICIAN'S NPI # _____
- PHYSICIAN'S SIGNATURE: _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

**INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR ORTHOTICS, PROSTHETICS
AND DIABETIC SHOES**

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #: Indicate the patient's name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.

DATE OF SERVICE: Indicate the date of service (DOS). The date of service must be the same as the delivery date.

PROVIDER'S NAME, DME # AND NPI#: Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.

PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER: Indicate the provider's physical address (provider's location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician.
Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).

QUESTION SECTION: This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.

DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.

PRESCRIPTION DATE: Indicate the prescription date. The prescription date must be within 90 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.

PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR ENTERAL NUTRITION**

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

- (1) Recipient's name: _____ Medicaid # (10 digits): _____
- (2) DOB: ____ / ____ / ____ Sex: ____ HT: _____ (in) WT: _____ Date of Service: _____
- (3) Provider's name: _____ Provider's DME #: _____ NPI #: _____
- (4) Street address: _____ City: _____ State: ____ Zip: _____ Local telephone #: _____
- (5) Provider's signature: _____ Date: _____
- (6) LIST ALL PROCEDURE CODES ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR ENTERAL NUTRITION.

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: IF FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

- (7) Diagnosis codes (ICD): _____ Diagnosis (s): _____

(8) Does the patient have permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel? Yes _____ No _____.

Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's over all health status? Yes _____ No _____.

Product name (s): _____

Total calories Per Day: _____

The method of administration: Syringe ____ Gravity ____ Pump ____ Does not apply ____.

Does the patient have a documented allergy or intolerance to semi-synthetic nutrients? Yes _____ No _____.

Is additional information attached on separate sheet? ____ Yes ____ No (If "yes," enter recipient's name & Medicaid I.D. number on attachment)

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____

(10) Enter the prescription date: _____

(11) Duration of need (Maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN'S NAME: _____ PHYSICIAN'S NPI # _____

PHYSICIAN'S SIGNATURE _____ DATE ____ / ____ / ____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR ENTERAL NUTRITION

SECTION A: MUST BE COMPLETED BY DME PROVIDER

- RECIPIENT'S NAME AND MEDICAID #:** Indicate the patient's name and his/her Medicaid # (10 digits).
- PATIENT DOB, SEX, HEIGHT, WEIGHT:** Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.
- DATE OF SERVICE:** Indicate the date of service (DOS). The date of service must be the same as the delivery date.
- PROVIDER'S NAME, DME # AND NPI #:** Indicate the name of the DME company (Provider name), Provider's DME # and NPI #.
- PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:** Indicate the provider's physical address (provider's location) and telephone number.
- PROVIDER SIGNATURE AND DATE:** Signature of DME provider representative and date.
- HCPCS CODES:** List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

- DIAGNOSIS CODES:** In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).
- QUESTION SECTION:** This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.
- DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:** Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.
- PRESCRIPTION DATE:** Indicate the prescription date. The prescription date must be within 90 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.
- EST. LENGTH OF NEED:** Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.
- PHYSICIAN ATTESTATION:** The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.
- PHYSICIAN SIGNATURE AND DATE:** After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR PARENTERAL NUTRITION**

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

- (1) Recipient's name: _____ Medicaid # (10 digits): _____
- (2) DOB: ____/____/____ Sex: __ HT: _____ (in) WT: _____ Date of Service: _____
- (3) Provider's name: _____ Provider's DME #: _____ NPI #: _____
- (4) Street address: _____ City: _____ State: ____ Zip: _____ Local telephone #: _____
- (5) Provider's signature: _____ Date: _____
- (6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR PARENTERAL NUTRITION:

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

- (7) Diagnosis codes (ICD): _____ Diagnosis (s): _____

- (8) Does the patient have severe permanent disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the patient's overall health status? Yes _____ No _____.

Formula components:

Amino Acid. _____ (ml/day) _____ concentration% _____ gms protein/day

Dextrose. _____ (ml/day) _____ concentration%

Lipids. _____ (ml/day) _____ days/weeks _____ concentration%.

Check the method of administration: Central line _____ Hemodialysis access line _____ Peripherally inserted catheter (PIC) _____

Is additional information attached on separate sheet? ___Yes ___No (If "yes", enter recipient's name & Medicaid I.D. number on attachment)

- (9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____
- (10) Enter the prescription date: _____
- (11) Duration of need (Maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN'S NAME: _____ PHYSICIAN'S NPI # _____

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN SECTION 2 OF THE DME MEDICAID PROVIDER MANUAL.

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #: Indicate the patient's name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.

DATE OF SERVICES: Indicate the date of service (DOS). The date of service must be the same as the delivery date.

PROVIDER 'S NAME, DME # AND NPI #: Indicate the name of the DME company (Provider name), Provider's DME # and NPI #.

PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER: Indicate the provider's physical address (provider's location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).

QUESTION SECTION: This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.

DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.

PRESCRIPTION DATE: Indicate the prescription date. The prescription date must be within 90 days of the date of treating /ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.

PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
 MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
 FOR OXYGEN**

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

- (1) Recipient's name: _____ Medicaid # (10 digits): _____
- (2) DOB ___/___/___ Sex: ___ HT: _____ (in) WT _____ Date of service: ___/___/___
- (3) Provider's name: _____ Provider's DME #: _____ NPI #: _____
- (4) Street address: _____ City: _____ State: ___ Zip: _____ Local telephone #: _____
- (5) Provider's signature: _____ Date: _____
- (6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT:

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD) _____ (Descriptions): _____

(8) ANSWERS	ANSWER QUESTIONS 1-9. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted)
a) _____ mm Hg b) _____ % c) ___/___/___	1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test, Enter date of test (c)
Y N	2. Was the test in Question 1 performed EITHER with the patient in a chronic stable state as an outpatient OR within two days prior to discharge from an inpatient facility to home?
1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX	4. Physician/provider performing test in Question 1 (and, if applicable, Question 7) Print/type name and address below NAME: _____ ADDRESS: _____
Y N D	5. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D
_____ LPM	6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "X"

IF PO2 = 56-60 OR OXYGEN SATURATION = < 89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.

Y N 7	7. Does the patient have dependent edema due to congestive heart failure?
Y N D	8. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
Y N D	9. Does the patient have a hematocrit greater than 56%?

NAME OF PERSON ANSWERING SECTION C QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
 NAME: _____ TITLE: _____ EMPLOYER: _____

- (9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____
- (10) Please indicate the Prescription date: _____
- (11) Duration of need (maximum of 12 months): _____
 (Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN'S NAME _____ PHYSICIAN'S NPI # _____
 PHYSICIAN'S SIGNATURE _____ DATE / / (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #: Indicate the patient's name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.

DATE OF SERVICE: Indicate the date of service (DOS). The date of service must be the same as the delivery date.

PROVIDER'S NAME, DME # AND NPI#: Indicate the name of the DME company (Provider name), Provider's DME # and NPI #.

PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER: Indicate the provider's physical address (provider's location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).

QUESTION SECTION: This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, or "D" for does not apply.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the question of Section B, he/she must print his/her name, give his/her professional title and name of his/her employer where indicated. If the physician is answering the question, this space may be left blank.

DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.

PRESCRIPTION DATE: Indicate the prescription date. The prescription date must be within 90 days of the date of treating /ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.

PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF DURABLE MEDICAL EQUIPMENT
CERTIFICATE OF REPAIR AND LABOR COST**



TO BE COMPLETED BY ENROLLED DME PROVIDER

(1) RECIPIENT'S NAME:

(2) RECIPIENT'S MEDICAID # (10 DIGITS):

(3) BRAND NAME OF EQUIPMENT:

(4) DATE OF REPAIR AND/OR LABOR:

(5) SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED:

(6) ESTIMATED COST OF REPAIR:

(7) GIVE A DETAILED DESCRIPTION OF THE TYPE OF REPAIR AND/OR LABOR TO BE PERFORMED ON EQUIPMENT:

(8) PROVIDER'S NAME:

PROVIDER ID and/or NPI:

(9) STREET ADDRESS:

CITY:

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF REPAIR AND LABOR COST

LINE 1	RECIPIENT'S NAME	Enter recipient's full name.
LINE 2	RECIPIENT'S MEDICAID #	Enter recipient's 10-digit Medicaid number.
LINE 3	BRAND OF EQUIPMENT	Enter the brand name of the equipment you are repairing.
LINE 4	DATE OF REPAIR AND/OR LABOR	Enter the date the repair and/or labor was performed.
LINE 5	SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED	Specify equipment being repaired.
LINE 6	ESTIMATED COST OF REPAIRED	Enter estimated cost of repair. This cost must be itemized if you are repairing more than one item. Please use the additional space at the bottom of this form if needed.
LINE 7	GIVE A DETAILED DESCRIPTION OF THE TYPE OF REPAIR AND/OR LABOR TO BE PERFORMED ON EQUIPMENT	Give a detailed description of what type of repair was performed.
LINE 8	PROVIDER'S NAME & PROVIDER ID AND/OR NPI	Enter provider's name and Medicaid DME number and/or National Provider Identifier.
LINE 9	STREET ADDRESS AND CITY	Enter provider's street address and city.



JUSTIFICATION FOR HOME UTERINE ACTIVITY
MONITOR/SUPPLIES (HUAM)
FOR SUBCUTANEOUS TOCOLYTIC THERAPY

PART I – (ALL INFORMATION MUST BE PRINTED)

Patient's Name	Medicaid #:
Date Telephone Order/Written Order Given:	
Patient's Expected Date of Delivery:	
Provider's NPI or Medicaid ID:	

PART II

The patient must have a gestational age of at least 24 weeks, but not more than 35 weeks AND meet AT LEAST ONE of the following criteria which necessitates a home uterine activity monitor/supplies and/or subcutaneous tocolytic therapy:

(AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE CHECKED)

- _____ Has experienced idiopathic pre-term labor that has required or will require hospitalization for IV tocolytic therapy.
- _____ Multiple gestation, three (3) or more fetuses, that has required or will require hospitalization for IV tocolytic therapy.
- _____ Patient has uterine anomalies or placenta previa that has required or will require hospitalization for IV tocolytic therapy.

PART III

Additionally, the patient must also meet ALL of the following criteria:

- 1) The patient has been diagnosed with pre-term labor based on uterine activity and/or cervical changes.
- 2) The patient has been stabilized by tocolytic medication.
- 3) There are no contraindications to the continuation of this pregnancy.
- 4) There is no fetal distress.
- 5) The patient's membranes are intact.
- 6) The patient is on homebound status and is agreeable to bed rest activities.
- 7) The patient has a telephone and is agreeable to daily phone contact and frequent physician follow-up.
- 8) The patient would have to be hospitalized for uterine activity monitoring and/or subcutaneous tocolytic therapy, if this service were not offered.
- 9) If the patient is hospitalized, this service will allow her to be discharged.
- 10) The patient is assigned to a delivering physician who has back up coverage in his/her absence.

PART IV Physician Certification

I, _____ (Ordering/Treating Physician's Name) certify that _____ (Patient's Name), qualifies for Home Uterine Activity Monitoring/Supplies for Subcutaneous Tocolytic Therapy based on medical necessity and that the patient meets the above criteria.

Ordering/Treating Physician's Signature:	Date:
Physician UPIN/License #:	Phone #:

This form **MUST** be signed within 60 days of ordering service.