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 Form Showing TPL Denial with NPI	02/2012
	Sample Remittance Advice (four pages)	04/2014
	ASD Fax Cover Sheet	04/2018
	Autism Spectrum Disorder (ASD) LIP Provider Application	03/2018
	Presumptive Eligibility Tool for Physician Use in the Medical Care Home	09/2025
	Autism Diagnostic Tool for Physician Use in the Medical Care Home	09/2025

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)	

SCDHHS Form 126 (revised 06/07)

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:

◯ 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:

- ◯ 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:_____

DHHS Form 130 Revision date: 03-13-2007

South Carolina Department of Health and Human Services
Form for Medicaid Refunds

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

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. **Attach appropriate document(s) as listed in item 8.**

1. Provider Name: _____

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

OR

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

4. Person to Contact: _____ **5. Telephone Number:** _____

6. Reason for Refund: [check appropriate box]

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

☐ Medicare
- ( ) Full payment made by Medicare
- ( ) Deductible not due
- ( ) Adjustment made by Medicare

☐ Requested by DHHS (please attach a copy of the request)

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

7. Patient/Service Identification:

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

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

☐ Medicaid Remittance Advice (required)

☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)

☐ Explanation of Benefits (EOMB) from Medicare (if applicable)

☐ Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

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

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

Contact Person: _____ Phone #: _____ Date: _____

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

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

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

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

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

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

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

- new policy number is _____

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

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

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

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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER _____ **DOS** _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

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

_____

(SIGNATURE AND DATE)

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

Revised 04/2014

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

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

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

1. Provider Name: _____

2. Medicaid Legacy Provider # _____ (Six Characters)

   NPI# _____ Taxonomy _____

3. Person to Contact: _____ Telephone Number: _____

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

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

5. Street Address for delivery of request:

   Street: _____

   City: _____

   State: _____

   Zip Code: _____

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

   Request Processing Fee - $20.00

   Page(s) copied - .20 per page

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

_____ _____

Authorizing Signature **Date**

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 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)

- ☐ 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: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature:_____ Date: _____

HEALTH INSURANCE CLAIM FORM

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

Alcohol & Drug Rehabilitation Services
Sample Claim Form Showing TPL Denial
with NPI

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) X | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN X (ID#) | FECA BLK LUNG (ID#) | OTHER (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 X F

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 | Spouse | Child | Other

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: A1111111

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES | NO X

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M F

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES | NO X PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC): 0 00

c. RESERVED FOR NUCC USE: 22

c. OTHER ACCIDENT? YES | NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: 401

d. INSURANCE PLAN NAME OR PROGRAM NAME: 401

10d. CLAIM CODES (Designated by NUCC): 1

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO — If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 295 32 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 01 07 14	01 07 14	11		H0001			102 00	1		ZZ	1212121212
										NPI	1234567890
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 555555555 X

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 102 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use 102 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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (555)5555555

ABC Provider
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Sample Remittance Advice (page 1)

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

PROVIDER ID. AB00080000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE: 02/14/2014

PAGE: 1

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				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: $0.00

MEDICAID PG TOT: $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

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. | DEPT OF HEALTH AND HUMAN SERVICES | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

AB00080000 | SOUTH CAROLINA MEDICAID PROGRAM | REMITTANCE ADVICE | 02/28/2014 | 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: $0.00 | MEDICAID PG TOT: $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

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 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: 0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: $243.71

ADJUSTMENTS: $193.71-

CHECK TOTAL: $50.00

CERTIFIED AMT: 0.00

CHECK NUMBER: 4197304

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

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.: 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 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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster
Governor

Joshua D. Baker
Director

ASD FAX COVER SHEET

CONFIDENTIAL INFORMATION ENCLOSED

DATE: _____
TO: _____
Telephone #: _____
Fax #: _____
FROM: _____
Telephone #: _____
Fax #: _____

Total Number of Pages Transmitted (Including Cover Sheet) _____

Please check each document that is submitted in this fax:

- ☐ Initial Authorization Request
  - ☐ Comprehensive Assess/Testing Report
  - ☐ Behavior Identification Assessment Results
  - ☐ Individualized Plan of Care
  - ☐ SCDHHS ASD Prior Authorization Request Form
- ☐ Continuation of Treatment Authorization Request
  - ☐ Two 90-day Summary Reports
  - ☐ Individualized Plan of Care
  - ☐ SCDHHS ASD Prior Authorization Request Form
- ☐ Annual Treatment Authorization Request
  - ☐ Two 90-day Summary Reports
  - ☐ Behavior Identification Assessment Results
  - ☐ Individualized Plan of Care
  - ☐ SCDHHS ASD Prior Authorization Request Form

The Division of Behavioral Health—ASD program
P. O. Box 8206 Columbia South Carolina 29202-8206
803.898.2136

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

Autism Spectrum Disorder (ASD) LIP Provider Application

PROVIDER INFORMATION	
Provider Name:	
Provider NPI:	
Provider Medicaid ID #	
License #	
Address:	
City / State / Zip Code	
Phone Number	

EVIDENCE BASED PRACTICE (EBP) PROFICIENCIES	
NAME OF EBP	**YEARS OF EXPERIENCE**

Describe your experience providing services to clients with ASD including length of time:

I attest that the aforementioned information is accurate.

Printed name: _____

Signature: _____ Date: _____

All applicable EBP certifications must be submitted with the application.

Please fax application to 803-255-8204 or send electronically to asdprovider@scdhhs.gov.

Presumptive Eligibility Tool for Physician Use in the Medical Care Home

Patient Information

Name: _____ Phone: (_____)_____ DOB: _____ Gender: _____

Address: _____
Street City State Zip Code

Parent/Caregiver Information

Name: _____ Relationship: _____ Legal Guardian: ☐ Yes ☐ No

Phone: (____)_____ Email: _____

Primary Care Physician (MD/DO)

Physician's Name: _____ Phone: (_____)_____

Address: _____
Street City State Zip Code

As the licensed physician conferring presumptive eligibility, I certify that:

☐ Patient is between the ages of 18 and 36 months at the time of eligibility determination

☐ The assessment was completed in its entirety directly by a physician with SCDHHS-verified training in the RITA-T or STAT

☐ Hearing and vision concerns have been considered, and appropriate referrals have been made

☐ Patient has been referred to Early Intervention Services (IDEA Part C/BabyNet) (18-30 months) BABYNET

☐ Patient has been referred to their school district to obtain an evaluation for school-based services (IDEA Part B) (30-36 months) Child Find - OSES

☐ Patient has been referred to appropriate therapies: speech therapy, occupational therapy, physical therapy

☐ Patient has been referred to applied behavior analysis (ABA) therapy

☐ Patient has been referred to their regional Developmental Evaluation Center (DEC) or other clinician/practice capable of completing a comprehensive diagnostic assessment (CDA).

☐ Patient's history and clinical observations indicate risk for the development of autism spectrum disorder and warrant presumptive eligibility for ABA therapy while they await a comprehensive diagnostic assessment.

☐ Patient's caregiver has received counseling that presumptive eligibility for ABA therapy **IS NOT** a medical diagnosis of autism and their child's eligibility for ABA therapy will lapse without documentation of a comprehensive diagnostic assessment that includes a DSM diagnosis of autism spectrum disorder, before the child's 6th birthday.

☐ Patient's caregiver has received counseling that presumptive eligibility for ABA therapy **DOES NOT** automatically extend or affect eligibility for state-specific early intervention services, school-based services through the South Carolina Department of Education, or services through South Carolina's Office of Intellectual and Developmental Disabilities.

Clinical tools used and included in attached clinical note:

Primary Autism Screening: ☐ M-CHAT-R ☐ CSBS-ITC ☐ SWYC:POSI ☐ Risk Score/Level: _____

Secondary Autism Screening: ☐ STAT **≥ 2.00** ☐ RITA-T **≥ 12** ☐ Risk Score: _____

ICD-10 Codes documented (DO NOT use code F84.0 as F84.0 represents a diagnosis of autism spectrum disorder)

☐ **R62.0** Delayed Milestone in Childhood

☐ **Z13.41** Encounter for Autism Screening

☐ **Other:**_____

Physician (MD/DO) Signature: _____ Date: _____

Physician (MD/DO) Name (Print): _____

SC Medical License: _____

Business/Practice Name: _____

Autism Diagnostic Tool for Physician Use in the Medical Care Home

Patient Information

Name: _____ Phone: (_____)_____ DOB: _____ Gender: _____

Address: _____
Street City State Zip Code

Parent/Caregiver Information

Name: _____ Relationship: _____ Legal Guardian: ☐ Yes ☐ No

Phone: (____)_____ Email: _____

Primary Care Physician (MD/DO)

Physician's Name: _____ Phone: (_____)_____

Address: _____
Street City State Zip Code

Autism Diagnosis Information

As the licensed physician conferring the diagnosis, I certify that:

☐ Patient is between the ages of 18 and 36 months at time of new diagnosis and the validated secondary autism screener was completed directly by the physician, ***OR***

☐ A prior evaluation was reviewed by the physician to ensure DSM criteria for ASD were met.

☐ Hearing and vision concerns have been considered, and appropriate referrals have been made

☐ Patient has been offered a referral to Pediatric Genetics

☐ Patient has been referred to Early Intervention Services (IDEA Part C/BabyNet) (18-30 months) BABYNET

☐ Patient has been referred to their school district to obtain an evaluation for school-based services (IDEA Part B) (30-36 months) Child Find - OSES

☐ Patient has been referred to the Office of Intellectual and Developmental Disabilities (OIDD)

☐ Patient does not have any complex psychosocial and medical factors that would prevent a diagnosis and necessitate a referral to a subspecialist.

☐ Patient has been referred to appropriate therapies: speech therapy, occupational therapy, physical therapy

☐ Patient has been offered a referral to applied behavior analysis (ABA) therapy

☐ Patient's history and clinical observations suggest that Diagnostic and Statistical Manual-5th Edition, Text Revision (DSM-5-TR) criteria for autism spectrum disorder have been met, as documented in the Checklist below.

If patient management has not included any of the above referrals, please detail your clinical rationale on a separate page.

Clinical tools used and included for a new diagnosis:

Developmental Assessment: ☐ ASQ ☐ PEDS-R ☐ CDI ☐ Other: _____

Primary Autism Screening: ☐ MCHAT ☐ CSBS-ITC ☐ SWYC:POSI ☐ Risk Level / Score: _____

Secondary Autism Screening: ☐ **STAT ≥ 3.00** ☐ **RITA-T ≥ 18** ☐ Risk Score: _____

☐ **OR Prior evaluation has been attached to support prior diagnosis of ASD**

ICD-10 Code:

☐ **F84.0** Autism Spectrum Disorder

Physician Name (MD/DO) (Print): _____

Physician (MD/DO) Signature: _____ Date: _____

SC Medical License: _____
Business/Practice Name: _____

DSM-5-TR Checklist

First and Last Name of Member	Date of Birth (MM/DD/YYYY)	Medicaid ID #: XXXXXXXXXXX

		Autism Spectrum Disorder	
Note: *If the individual has a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified (PPD-NOS), please check this box, then complete the checklist below to evaluate the previous diagnosis to autism spectrum disorder.*			
A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive, see text), all 3 must be present:		**Present**	**Not Present**
1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.			
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.			
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.			
Severity is based on social communication impairments (check one)	☐ **1. Requiring Support** ☐ **2. Requiring Substantial Support** ☐ **3. Requiring Very Substantial Support**		
B. Restricted, repetitive patterns of behavior, interests, or activities, manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive)		**Present**	**Not Present**
1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).			
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).			
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).			
4. Hyper - or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).			
Severity is based on restrictive repetitive patterns of behavior (check one)	☐ **1. Requiring Support** ☐ **2. Requiring Substantial Support** ☐ **3. Requiring Very Substantial Support**		

First and Last Name of Member	Date of Birth (MM/DD/YYYY)	Medicaid ID #: XXXXXXXXXXX

	Yes	No
C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities or may be masked by learned strategies in later life).		
D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.		
E.* These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. *Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnosis of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.		

	Yes	No
Autism Spectrum Disorder criteria met?		
	With	**Without**
With or without accompanying intellectual impairment?		
With or without accompanying language impairment?		

Physician Name	Physician Credentials (MD/DO)
Signature	**Date (MM/DD/YYYY)**