

FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
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-1450	UB-04 (blank; sample only)	
	Sample Remittance Advice	
	Abortion Statement	
	Abortion Statement (sample version)	
	Alcohol and Drug Medical Assessment (two pages)	09/1990
DHHS 185	Community Long-Term Care Level of Care Certification Letter (two pages)	11/2003
	Community Long-Term Care Notification Form	12/2004
DHHS 218	ESRD Enrollment	06/2007
DHHS 687	Consent for Sterilization	09/2025
	Notice of Termination of Administrative Days	09/2010
	Notification of Administrative Days Coverage	05/2012
	Referral Request Form for Out-of-State Services (three pages)	10/2022
DHHS 1716ME	Request for Medicaid ID Number	04/2017
	Request for Prior Approval Review By KEPRO	06/2012
	Surgical Justification Review for Hysterectomy	08/2017
	Surgical Justification Review for Hysterectomy (sample version)	08/2017
	Transplant Prior Authorization Request Form & Instructions (two pages)	05/2022



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
Form for Medicaid Refunds**

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

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

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

1. Provider Name: _____

2. Medicaid Legacy Provider #
(Six Characters)

OR

3. NPI#

& Taxonomy

4. Person to Contact: _____

5. Telephone Number: _____

6. Reason for Refund: [check appropriate box]

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

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

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

☐ Other, describe in detail reason for refund:

7. Patient/Service Identification:

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

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

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

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

Mail to: SC Department of Health and Human Services

Cash Receipts

Post Office Box 8355

Columbia, SC 29202-8355



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

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

Contact Person: _____ Phone #: _____ Date: _____

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

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

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

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

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

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

Fax:
803-252-0870

or

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



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

PROVIDER _____ **DOS** _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

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

(SIGNATURE AND DATE)

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

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

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

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

1. Provider Name: _____

2. Medicaid Legacy Provider # _____ (Six Characters)

NPI# _____ Taxonomy _____

3. Person to Contact: _____ Telephone Number: _____

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

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

5. Street Address for delivery of request:

Street: _____

City: _____

State: _____

Zip Code: _____

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

Request Processing Fee - \$20.00

Page(s) copied - .20 per page

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

Authorizing Signature

Date


Submit your Claim Reconsideration request to:
Fax: 1-855-563-7086

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

CLAIM RECONSIDERATION FORM

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

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ Medicaid Beneficiary ID: _____

Section 2: Provider Information

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

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

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

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

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

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

Section 4: Claim Reconsideration Information

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

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



Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____

Date: _____

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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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.	T \$0.00	V \$675.00	STATUS CODES: P = PAYMENT MADE R = REJECTED S = IN PROCESS 9999999 Y CHECK NUMBER	PROVIDER NAME AND ADDRESS Z
	SCHAP PG TOT	MEDICAID PG TOT		
	U \$0.00	W \$675.00		
	SCHAP TOTAL	MEDICAID TOTAL		
	X \$675.00			
	* CHECK TOTAL			

PROVIDER ID. 000099999
 777777777 **A** DEPT OF HEALTH AND HUMAN SERVICES
 SOUTH CAROLINA MEDICAID PROGRAM

IN/OUT-PATIENT SERVICES
 REMITTANCE ADVICE

PAYMENT DATE
 02/28/2014 **B**

PAGE
 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PERIOD MMDDYY-MMDD	DAYS	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	CO PY	LV CL	POS IND	TYP REM	XOV IND
V99999 C	999999 D 999999Z	0213 E 213	F 0	3,015.88	675.00	P 222222222	B B JACKSON					
V99999999	9999999999999999Z	021414-0214	1 0	3,690.88	0.00	R 111111111	A B SMITH					
							EDITS: L00 758	L00	990			
							EDITS: L06 714					
V99999999	9999999999999999Z	021414-0214	1 0	3,690.88	0.00	R 111111111	A B SMITH					
							EDITS: L00 758 AA	L00	990			
							EDITS: L06 714					
TOTALS		CLAIMS P 3	Q 0	10,397.64	675.00							

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.

T \$0.00	V \$675.00
SCHAP PG TOT	MEDICAID PG TOT
U \$0.00	W \$675.00
SCHAP TOTAL	MEDICAID TOTAL
	X \$675.00
	* CHECK TOTAL

STATUS CODES:

P = PAYMENT MADE
 R = REJECTED
 S = IN PROCESS
 999999 **Y**
 CHECK NUMBER

PROVIDER NAME AND ADDRESS

Z

PROVIDER ID. 000099999
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| 777777777 | **A** DEPT OF HEALTH AND HUMAN SERVICES
+-----+
SOUTH CAROLINA MEDICAID PROGRAM

IN/OUT-PATIENT SERVICES
REMITTANCE ADVICE

PAYMENT DATE
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| 02/28/2014 | **B**
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PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PERIOD MMDDYY-MMDD	DAYS	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	CO PY	DRG	TYPE REIM	XOV IND
C	D	E	F	G	H	I	J	K	L	M	N	O
L0000000	9999999999999900Z	021314-0213	1 1	1,339.25	429.37	P	1234567890	A B SMITH		391	A	
L0000000	9999999999999900Z	101513-1027	12 12	24,536.78	7,162.25	P	1234567890	C B JONES	D	138	C	
L0000000	9999999999999900Z	102213-1026	4 4	3,088.25	429.37	P	1234567890	J Q DOE		391	A	
L0000000	9999999999999900Z	102213-1026	4 4	13,085.84	3,720.97	P	1234567890	R R ROE	D	370	A	
L0000000	9999999999999900Z	101813-1021	3 3	13,152.95	3,438.85	P	1234567890	C D SMITH	D	336	A	
L0000000	9999999999999900Z	102813-1030	2 2	4,672.75	1,394.10	P	1234567890	A B JOHNSON		373	A	
L0000000	9999999999999900Z	102913-1030	1 0	2,873.00	0.00	R	1234567890	J Q PUBLIC EDITS: L06 761		143	U	
TOTALS		CLAIMS 27	74	317,236.27	50,011.83							
		P	Q	R	S							

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.

T \$0.00	V \$44,539.54
+-----+	+-----+
SCHAP PG TOT	MEDICAID PG TOT
+-----+	+-----+
U \$0.00	W \$50,011.83
+-----+	+-----+
SCHAP TOTAL	MEDICAID TOTAL
+-----+	+-----+
X \$50,011.83	
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* CHECK TOTAL	

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS

| 9999999 | **Y**
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CHECK NUMBER

PROVIDER NAME AND ADDRESS

Z

ADJUSTMENTS

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BANK NAME: BRANCH BANK & TRUST BANK NUMBER: ACCOUNT #:
NOTIFY MEDICAID PROVIDER ENROLLMENT BEFORE CLOSING OR CHANGING YOUR BANK ACCOUNT.

ABORTION STATEMENT

This certification meets FFP requirements and must include all of the aforementioned criteria.

Patient's Name: _____

Patient's Medicaid ID#: _____

Patient's Address: _____

Physician Certification Statement

I, _____ certify that it was necessary to terminate the pregnancy of _____
_____ for the following reason:

a. () Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition:

b. () The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.

c. () The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

Physician's Signature

Date

The patient's certification statement is only required in cases of rape or incest.

Patient's Certification Statement

I, _____ certify that my pregnancy was the result of an act of rape or incest.

(Patient's Name)

Patient's Signature

Date

Both the completed Abortion Statement and appropriate medical records must be submitted with the claim form.

ABORTION STATEMENT

This certification meets FFP requirements and must include all of the aforementioned criteria.

Patient's Name: Jane Doe

Patient's Medicaid ID#: 1234567891

Patient's Address: 111 Maple Drive
Anytown, SC 29999

Physician Certification Statement

I, John Brown certify that it was necessary to terminate the pregnancy of Jane Doe
_____ for the following reason:

a. () Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition:

End Stage Renal Failure and Cancer

b. () The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.

c. () The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

John Brown

12/12/04

Physician's Signature

Date

The patient's certification statement is only required in cases of rape or incest.

Patient's Certification Statement

I, _____ certify that my pregnancy was the result of an act of rape or
incest.

(Patient's Name)

Patient's Signature

Date

Both the completed Abortion Statement and appropriate medical records must be submitted with the claim form.

Alcohol and Drug Medical Assessment

Patient's Name (Last, First, MI) and I.D. #

Medicaid Client #

Date of Medical Assessment

Physician's Name and Address

1. Brief medical history to include hospital admissions, surgeries, allergies, present medications, information (where appropriate) about shared needles, sexual activity/orientation and history of hepatitis and liver disease.

2. History of patient /family involvement with alcohol/drugs.

3. Assessment of patient nutritional status.

4. Physical examination to include, but not be limited to, vital signs, inspection of ears, nose, mouth, teeth and gums. Also, inspection of skin for recent and/or old needle marks/tracking, abscesses or scarring from healed abscesses.

5. General assessment of patient cardiovascular system, respiratory system, gastro-intestinal system and neurological status.

6. Screening for anemia (hematocrit or hemoglobin may be used when physician has machinery available in office).

7. It is ordered that _____ receive alcohol/drug rehabilitative services.

Physician's Signature and Date

SOUTH CAROLINA COMMUNITY LONG TERM CARE
LEVEL OF CARE CERTIFICATION LETTER
FOR
MEDICAID-SPONSORED NURSING HOME CARE

NAME: _____ COUNTY OF RESIDENCE: _____

SOCIAL SECURITY #: _____ MEDICAID #: _____

LOCATION AT ASSESSMENT: _____

South Carolina Community Long Term Care has evaluated your application and has determined that:

☐ According to Medicaid criteria, you do not meet requirements for skilled or intermediate care. This does not mean that you do not need personal or other medical care, and does not mean that you cannot be admitted to a long term care facility. It does mean that the Medicaid program will not be responsible to pay for your care in a long term care facility. Please do not hesitate to contact this office if there is a change in your health status or you become more limited in your ability to care for yourself.

☐ According to Medicaid criteria, you meet the requirements to receive long term care at the following level:

☐ SKILLED ☐ INTERMEDIATE

This Certification Letter is not an approval for financial eligibility for Medicaid. You must establish financial eligibility with the County Department of Social Services.

This letter must be presented to the long term care facility to which you are admitted. IF YOU HAVE NOT ENTERED A FACILITY BY THE EXPIRATION DATE BELOW, YOU MUST CONTACT THE CLTC OFFICE AT _____ TO REAPPLY.
Telephone No. _____

If you change locations from where your assessment was made (i.e., hospital to home) your assessment must be updated and a new effective period established.

Medicaid certification is automatically cancelled when a client enters a facility with a payment source other than Medicaid; you must again be certified before a Medicaid conversion will be allowed.

☐ ADMINISTRATIVE DAYS ☐ SUBACUTE CARE

☐ If the location of care is hospital, your assessment must be re-evaluated and a new effective period established PRIOR TO TRANSFER TO A LONG TERM CARE FACILITY.

FOR LONG TERM CARE FACILITY USE

☐ TIME-LIMITED CERTIFICATION. LTC FACILITY STAFF MUST SUBMIT AN ASSESSMENT AT LEAST FIVE WORKING DAYS BEFORE THE EXPIRATION DATE DUE. (See Expiration Date Below)

☐ THIS CLIENT HAS BEEN RECEIVING HOME AND COMMUNITY-BASED SERVICES FROM CLTC. CONTACT THE DSS OFFICE IN THE CLIENT'S COUNTY OF RESIDENCE TO DETERMINE IF THE 30 CONSECUTIVE DAYS REQUIREMENT HAS BEEN MET.

Effective Date: _____ Expiration Date: _____

Nurse Consultant Signature: _____ Date: _____

☐ CLIENT ☐ CO. DSS ☐ LTC FACILITY ☐ PHYSICIAN ☐ HOSPITAL ☐ OTHER

SENT: Date: _____ Initials: _____

APPEALS

As a Medicaid nursing home or home and community-based waiver applicant/recipient, you have the right to a fair hearing regarding this decision. To initiate the appeal process, you or your representative must submit a written request to the following address no later than thirty (30) days from the receipt of this notification.

Division of Appeals and Fair Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

You may be eligible to receive continued benefits pending a hearing decision. If you are interested in continued benefits you must contact your CLTC representative before the effective date of the action indicated above. If the hearing decision is not in your favor, you may be required to repay Medicaid benefits received pending the decision to the South Carolina Department of Health and Human Services.

Please attach a copy of this notification with your request. You or your representative will be notified of the date, time and place the hearing will take place.

In your request for a fair hearing you must state with specificity which issues(s) you wish to appeal.

Unless a request is made within thirty (30) calendar days of receipt of this notification, this decision will be final and binding.

A request for a fair hearing is considered filed if postmarked by the thirtieth (30th) calendar day following receipt of this notification.

COMMUNITY LONG TERM CARE NOTIFICATION FORM

TO:

FROM: CLTC Central Office
Post Office Box 8206
Columbia, SC 29202-8206

CLIENT NAME:

SS#

MA#

- Client's level of care appears to be skilled. (THIS IS NOT A CERTIFIED LEVEL OF CARE. CLIENT INFORMATION MUST AGAIN BE REVIEWED PRIOR TO CERTIFICATION.)
- Client has been referred to you for case follow-up and services, as appropriate.

IF YOU DISAGREE WITH THIS DETERMINATION, PLEASE READ THE APPEALS NOTICE BELOW:

APPEALS

As a Medicaid recipient, you have the right to a fair hearing regarding this decision. To initiate the appeals process, you or your representative must submit a written request to the following address no later than thirty (30) days from the receipt of this notification.

Division of Appeals and Fair Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Please attach a copy of this notification with your request. You or your representative will be notified of the date, time, and place the hearing will take place. In your request for a fair hearing, you must state with specificity which issue(s) you wish to appeal.

Unless a request is made within thirty (30) calendar days of receipt of this notification, this decision will be final and binding.

A request for a fair hearing is considered filed if postmarked by the thirtieth (30th) calendar day following receipt of this notification.

Signature:

Date:

Copies sent to:

CLIENT ☐ HOSPITAL ☐ LTC FACILITY ☐ COUNTY DSS ☐
PHYSICIAN ☐ CAREGIVER/RESPONSIBLE PARTY ☐ OTHER ☐



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
ESRD ENROLLMENT FOR MEDICAID BENEFICIARIES**

PART I – PATIENT INFORMATION

Name:		Date of Birth:	Social Security No:
Address:		Medicaid ID No:	Medicare Eligible?
STREET OR RFD		Medicare Application Submitted?	
CITY STATE ZIP CODE		Yes Date:	
County:	Medicare No:	Effective Date:	Medicare Denied? ☐ Yes ☐ No

REASON FOR DENIAL: _____

PART II – TREATMENT INFORMATION – DIALYSIS

Date of First Treatment:	Transplant Candidate? ☐ Yes ☐ No
Name of Facility Transferred From:	
Mode of Treatment: ☐ HEMODIALYSIS ☐ PERITONEAL DIALYSIS ☐ SELF DIALYSIS	Home Dialysis: TYPE: _____ SUPPLIER: _____

PART III – MEDICAL TRANSPORTATION

Reimbursed by DSS? ☐ Yes ☐ No	Provider of Transportation:
--	-----------------------------

ESRD PROVIDER INFORMATION	DHHS USE ONLY
Clinic Name:	ESRD Enrolled:
NPI or Medicaid Provider ID:	Code:
Physician's Name:	Effective Date:
Form Completed By:	Approved By:
NAME TELEPHONE NO.	
TITLE DATE	Date Approved:
Mail To: ESRD SERVICES SCDHHS PO BOX 8206 COLUMBIA, SC 29202-8206	Comments:

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ . When I first asked

Doctor or Clinic

for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ . The discomforts, risks

Specify Type of Operation

and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____
Date

I, _____, hereby consent of my own free will to be sterilized by _____
Doctor or Clinic

by a method called _____ . My
Specify Type of Operation

consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature

Date

You are requested to supply the following information, but it is not required: (*Ethnicity and Race Designation*) (please check)

Ethnicity: _____ *Race (mark one or more):* _____

- | | |
|---|--|
| ☐ Hispanic or Latino | ☐ American Indian or Alaska Native |
| ☐ Not Hispanic or Latino | ☐ Asian |
| | ☐ Black or African American |
| | ☐ Native Hawaiian or Other Pacific Islander |
| | ☐ White |

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____

language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter's Signature

Date

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
Name of Individual

consent form, I explained to him/her the nature of sterilization operation _____, the fact that it is

Specify Type of Operation

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Signature of Person Obtaining Consent

Date

Facility

Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

_____ on _____
Name of Individual *Date of Sterilization*

I explained to him/her the nature of the sterilization operation

_____, the fact that it is _____

Specify Type of Operation

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery

Individual's expected date of delivery: _____

☐ Emergency abdominal surgery (*describe circumstances*): _____

Physician's Signature

Date

PAPERWORK REDUCTION ACT STATEMENT

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, SW., Washington, DC 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations. [43 FR 52165, Nov. 8, 1978, as amended at 58 FR 33343, June 17, 1993; 68 FR 12308, Mar. 14, 2003]

ADMISSION DATE

DATE

MEDICAID ID NUMBER

ATTENDING PHYSICIAN'S NAME

NOTICE OF TERMINATION OF ADMINISTRATIVE DAYS

This is to inform you that a nursing home bed has been found for you at _____
_____ in _____, South Carolina. The bed will be available to you
on _____. If you elect to remain in the hospital after this date, you
will be responsible for payment of all services provided to you by _____
_____ Hospital beginning on _____.

You may appeal this Notice of Termination with a written request to:

SCDHHS
Division of Appeals and Hearings
P. O. Box 8206
Columbia, SC 29202-8206

The appeal request must be received by SHHSFC within 30 calendar days from receipt of this
letter. If the appeal rules in your favor, you will not be responsible for additional charges.
However, if the appeal upholds the Notice of Termination, you are responsible for all charges
beginning on the date the nursing home bed was located.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of non-coverage of services from the _____
_____ at _____ on _____. I
understand that my signature below does not indicate that I agree with the notice, only that I have
received a copy of this notice.

(Signature of recipient or person acting on behalf of
the recipient)

(Time)

(Date)

cc: Division of Hospital Services
DHHS

ADMISSION DATE

DATE

MEDICAID ID NUMBER

ATTENDING PHYSICIAN'S NAME

NOTIFICATION OF ADMINISTRATIVE DAYS COVERAGE

This notice is to inform you that the hospital's Utilization Review Committee has determined that beginning _____ further acute hospital care is no longer necessary. Your condition, however, qualifies you for nursing home care.

Limited additional days in the hospital may be approved subject to Medicaid coverage regulations while you and your family actively seek a nursing home bed.

Once an available bed is located, Medicaid payment of your hospital bill will stop. If you refuse to accept an available nursing home bed and remain in the hospital, you will be personally responsible for the additional expense in the hospital.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of the Administrative Day Program from the _____ on _____.

I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of this notice.

(Signature of recipient or person acting on behalf of
the recipient)

(Date)

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

Send to: SCDHHS Bureau of Provider and Support Services Attn: Out-of-State Coordinator Fax: 803-255-8255	Date:	# of Pages (including cover):
	Point of Contact Information	
	Name	
	Phone	
	Fax	
	Email	

Please ensure all items on the checklist are included prior to submitting the packet.

Incomplete requests will not be processed. Please allow up to two weeks for processing.

- ☐ Valid point of contact information is provided for referring and out-of-state providers
- ☐ Completed and signed Form A – To be completed by South Carolina referring provider
- ☐ Completed and signed Form B – To be completed by the out-of-state (OOS) provider. This form indicates that the provider has been contacted and has confirmed, in writing, that they are enrolled or have begun to enroll in the South Carolina Healthy Connections Medicaid program and will accept Healthy Connections Medicaid reimbursement as payment-in-full
- ☐ One year of medical records/clinical notes that support the decision to refer out-of-state
- ☐ If Medicaid is not the primary insurance, prior authorization (PA)/denial from primary insurance is attached
- ✱ If no PA is required from primary insurance, please advise: _____

Confidentiality Note:

THIS MESSAGE IS INTENDED FOR THE USE OF THE PERSON OR ENTITY TO WHICH IT IS ADDRESSED AND MAY CONTAIN INFORMATION, INCLUDING HEALTH INFORMATION, THAT IS PRIVILEGED, CONFIDENTIAL, AND THE DISCLOSURE OF WHICH IS GOVERNED BY APPLICABLE LAW. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS INFORMATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS IN ERROR, PLEASE NOTIFY US IMMEDIATELY.
 THANK YOU.

FORM A

To be completed by the South Carolina referring provider.

All fields are required and failure to complete each section will cause a delay in processing.

Member Information						
Name	Date of Birth	SC Medicaid Number	Name of Guardian	Contact Phone Number		
Will member require meals, lodging and transportation (ancillary) assistance? Yes ☐ No ☐						
Services are (Select one): ☐ Inpatient ☐ Outpatient						
Ancillary assistance is provided for the member and one (1) escort for approved services, where applicable. Adequate advanced notice and <u>prior approval</u> from SCDHHS are mandatory prior to the broker arranging travel. Hotel accommodations are for outpatient services <i>only</i>. Retroactive reimbursement will not be approved.						
Referring Provider Information						
Facility Name	Provider Name		NPI SC Medicaid Legacy ID #	Contact Phone Number		
Clinical Information						
Condition requiring treatment						
<u>REQUIRED</u> Brief explanation of medical need to receive services outside of the South Carolina Medicaid Service Area (SCMSA). The SCMSA includes all of South Carolina and regions of North Carolina and Georgia within 25 miles of the South Carolina border.						
ICD-10 Diagnosis Code(s)			HCPCS/CPT Procedure Code(s)			
Patient is being referred to:						
Facility:		Provider(s):				
Date of service (if no appointment is scheduled, enter "tentative")			Date of return (refers to length of stay for the service)			

- I certify communication has been established with the out-of-state provider.

- I certify the aforementioned services are not available or provided within the South Carolina Medicaid Service Area (SCMSA).

Signature of Referring Provider

Date

FORM B

To be completed by the out-of-state rendering provider. Separate form to be completed
for each **individual** provider rendering/billing for services.

All fields are required.

Provider Information	
☐ Individual ☐ Facility	
Provider Name	NPI SC Medicaid Legacy ID #
Contact Phone Number	Fax Number
Member Name	Member Date of Birth

By signing below, the out-of-state facility and physician(s) certifies the following:

- Facility and physician(s) are enrolled or have initiated enrollment with South Carolina Healthy Connections Medicaid (if enrolling, please provide the 15-digit alpha-numeric Communication ID or a screenshot of the in-process application)
- Accepting South Carolina Healthy Connections Medicaid reimbursement as payment-in-full

Authorized Signature of Out-of-State Provider

Date

Printed Name of Authorized Representative

Please Note: If the out-of-state provider does not sign or indicates a reason for refusal, the referral request will not be processed or reviewed.

For information concerning enrollment and claims submission for out-of-state hospital providers, please see “**Out-of-State Hospitals**” in the *Hospital Services Provider Manual*. The most current version of the provider manual is maintained on the SCDHHS website at www.scdhhs.gov.

Services for members enrolled in managed care organizations (MCOs) are to be requested through the MCO using the entity’s prior authorization process.

For a complete copy of the out-of-state services policy, please refer to the *Physicians Services Provider Manual*. The most current version of the provider manual is maintained on the SCDHHS website at www.scdhhs.gov. If you have additional questions, please contact the Provider Service Center at (888) 289-0709, submit an inquiry at <http://www.scdhhs.gov/contact-us>, or contact your MCO representative at (803) 898-4614.

Request for Medicaid ID Number - Infant

I. Provider Information

Provider Name / Hospital Name			Date	
Provider Street Address	City	County	State	ZIP code
Provider Representative (First, Last Name)			Phone	

II. Mother's Information

First Name, Middle Name, Last Name			Date of Birth (mm/dd/yyyy)	
Street Address	City	County	State	ZIP code
Social Security Number		Medicaid ID#		

Is the mother covered by other health insurance? ☐ Yes ☐ No
 If yes, does the insurance cover Doctor Visits and Lab Tests? ☐ Yes ☐ No ☐ Unsure

Insurance Company : _____ Policy#: _____

III. Child's Information

First Name, Middle Name, Last Name (If not yet named, enter "Baby Boy" or "Baby Girl")			Date of Birth (mm/dd/yyyy)	
Street Address (If same as mother's, enter "Same")	City	County	State	ZIP code
Name of Birth Facility		County of Birth Facility		

Gender: ☐ Male ☐ Female

Has an application been made for a SSN for the child? ☐ Yes ☐ No

IV. Mail the Completed Form

Mail the completed form to:

SCDHHS - Central Mail
 PO Box 100101
 Columbia, SC
 29202-3101

Fax:

(803) 255-8200

PATIENT NAME _____
LAST FIRST MI

FACILITY _____	_____
NAME	NPI #

Revised: 06/01/12

**SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY**

THIS COMPLETED FORM AND A SIGNED "CONSENT FOR STERILIZATION" FORM MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.

PATIENT

NAME _____ MEDICAID # _____
LAST FIRST MI
BIRTHDATE _____ GRAVITY _____ PARITY _____
MONTH/DAY/YEAR

PROCEDURE CODE: _____ **DX CODE:** _____

HOSPITAL _____
NAME NPI (IF AVAILABLE)

PLANNED ADMISSION DATE _____ PLANNED SURGERY DATE _____

TYPE OF HYSTERECTOMY PLANNED _____

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:

HCT ____ HGB ____ CHECK ONE: PREMENOPAUSAL ____ POSTMENOPAUSAL ____

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:

PRIOR GYN SURGERY/DIAGNOSTIC PROCEDURES (INCLUDE COPIES OF ALL REPORTS):

OFFICE NOTES AND ALL SUPPORTING DOCUMENTATION (e.g., ULTRASOUND, OPERATIVE AND PATH REPORTS, ETC.) ARE REQUIRED FOR APPROVAL AND SHOULD BE ATTACHED TO THIS FORM.

ATTENDING PHYSICIAN'S NAME _____
LAST FIRST MI NPI

ADDRESS _____

CONTACT PERSON _____ TELEPHONE (____) _____

FAX (____) _____

SIGNATURE _____ DATE _____

ATTENDING PHYSICIAN

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY

THIS COMPLETED FORM AND A SIGNED "CONSENT FOR STERILIZATION" FORM MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.

PATIENT

NAME Jane Doe MEDICAID # 1234567891
LAST FIRST MI
BIRTHDATE 09/09/1970 GRAVITY 2 PARITY 2
MONTH/DAY/YEAR

PROCEDURE CODE: _____ DX CODE: _____
HOSPITAL Memorial Hospital 1234567890
NAME NPI (IF AVAILABLE)
PLANNED ADMISSION DATE 08/15/10 PLANNED SURGERY DATE 08/15/10
TYPE OF HYSTERECTOMY PLANNED Vaginal

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:

Dysfunctional uterine bleeding >3 mos and unresponsive
to hormonal therapy x 3 consecutive cycles, bleeding,
anemia with transfusion x 1. Neg. for endometrial
lesion per biopsy 10/04.

HCT 26 HGB _____ CHECK ONE: PREMENOPAUSAL ☒ POSTMENOPAUSAL _____

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:

D&C 10/05/09 Dx Lap. 11/09

PRIOR GYN SURGERY/DIAGNOSTIC PROCEDURES (INCLUDE COPIES OF ALL REPORTS):

OFFICE NOTES AND ALL SUPPORTING DOCUMENTATION (e.g., ULTRASOUND, OPERATIVE AND PATH REPORTS, ETC.) ARE REQUIRED FOR APPROVAL AND SHOULD BE ATTACHED TO THIS FORM.

ATTENDING PHYSICIAN'S NAME Brown Mary Z 1234567890
LAST FIRST MI NPI
ADDRESS 101 East Street Anywhere, SC 22222

CONTACT PERSON John Brown TELEPHONE (803) 123-4567
FAX (803) 123-4568

SIGNATURE Mary Brown, MD DATE 06/01/07
ATTENDING PHYSICIAN

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

Revised: 08/01/17

TRANSPLANT PRIOR AUTHORIZATION REQUEST FORM INSTRUCTIONS

The South Carolina Department of Health and Human Services (SCDHHS) may use guidelines that include clinical standards, protocols, or criteria regarding the treatment of specific conditions in determining whether to provide prior authorization.

General Information

- All transplant prior authorization requests require at least 10 days advance notice.
- Ensure most recent version of the Transplant Prior Authorization Request form is submitted.
- The referring South Carolina (SC) Medicaid provider must complete the form.
- All fields on the form must be completed.
- Providers seeking reimbursement for services must be credentialed with SC Medicaid.
- Incomplete prior authorization requests are administratively denied. Requests are considered only when completed and received before the service is provided.
- Include supporting clinical documentation (e.g., clinical notes, diagnostic studies, lab results)
- Authorization approval is not an authorization for payment. Payments are made based on the beneficiary's eligibility and benefits on the day of service.
- If the transplant service is available in state and this case is being referred outside of the South Carolina Medical Service Area (SCMSA), you must indicate why.

Requests for prior authorizations may be submitted to Kepro using one of the following methods.

Kepro Customer Service:	1-855-326-5219
Kepro Fax #	1-855-300-0082
For Provider Issues email:	atrezzoissues@Kepro.com

Transplant Prior Authorization Request Form

Omissions, generalities, and illegibility will result in the form being returned for completion or clarification. Please note that the approval of a transplant evaluation does not guarantee the approval of the actual transplant.

BENEFICIARY INFORMATION

NAME OF BENEFICIARY: _____ SC MEDICAID #: _____ DATE OF BIRTH: _____
 NAME OF GUARDIAN (if applicable): _____ CONTACT NUMBER: _____

PROVIDER INFORMATION

REFERRING PHYSICIAN

NAME OF REFERRING PHYSICIAN: _____ NPI: _____ SC MEDICAID #: _____
 TYPE OF TRANSPLANT: _____ TYPE OF ORGAN BEING RECEIVED: Living _____ Cadaveric _____
 EXPECTED DATE OF SERVICE: _____

RENDERING PHYSICIAN/FACILITY

NAME OF PHYSICIAN(S): _____ NAME OF FACILITY: _____
 FACILITY NPI: _____ FACILITY SC MEDICAID #: _____
 FACILITY ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 NAME OF CONTACT PERSON/COORDINATOR: _____
 TELEPHONE: _____ FAX: _____

DIAGNOSIS/PROCEDURE CODES and DESCRIPTIONS

ICD-10 DIAGNOSIS CODE(S)	DESCRIPTION
PROCEDURE CODE(S)	DESCRIPTION

REQUIRED DOCUMENTATION

Letter of Medical Necessity for the transplant, including the following:

- Summary of course of illness, current medications, smoking, alcohol, and drug abuse history must be six months free from use.
- Medical records, including physical exam, medical history, family history and laboratory assessments including serologies
- Letter to support the need to have the transplant performed outside of the South Carolina Medical Service Area (SCMSA) - if applicable.

I certify that the above information is correct, and that contact has been made with the Rendering Facility/Physician. I also certify that if the request is to a provider and/or facility outside of the SCMSA, that the service is not available and cannot be provided within the SCMSA.

 SIGNATURE OF REFERRING PHYSICIAN

 DATE