FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	02/2018
	Reasonable Effort Documentation	04/2014
	Duplicate Remittance Advice Request Form	09/2017
	Claim Reconsideration Form	11/2018
CMS-1500 (02/12)	Sample Claim Showing TPL Payment with NPI	02/2012
	Sample Remittance Advice (four pages)	04/2014
	Healthy Mothers, Healthy Futures Maternity Health Education Checklist (two pages)	
	Alcohol and Drug Medical Assessment (two pages)	09/1990
	DHHS Pediatric Sub-Specialists Certification Form	06/2015
	Abortion Statement	
DHHS 687	Consent For Sterilization	09/2025
	Surgical Justification Review for Hysterectomy	07/2017
	Request for Prior Approval Review	06/2012
	Allied Profession Supervision Form	08/2013
	Referral Request Form for Out-of-State Services (three pages)	10/2022
	Transplant Prior Authorization Request Form & Instructions (two pages)	05/2022
	Mental Health Form	09/2013
	Psychiatric Prior Authorization Form – Inpatient	06/2012
	Circumcision Prior Authorization Form	02/2011
	BOI Universal Screening Tool	04/2017

FORMS

Number	Name	Revision Date
	Universal 17-P Authorization Form	12/2013
	SCDHHS Behavioral Health Referral and Feedback Form	12/2013
	Hereditary Breast and Ovarian Cancer (HBOC)	08/2019
	Pharmacogenetic Genetic Testing Prior Authorization Request Form	03/2024

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:	
NPI or MEDICAID PROVIDER ID: (if applicable)	MEDICAID RECIPIENT ID NUMBER: (if applicable)
ADDRESS OF SUSPECT:	LOCATION OF INCIDENT:
	DATE OF INCIDENT:
COMPLAINT:	

NAME OF PERSON REPORTING: (Please print)	SIGNATURE OF PERSON REPORTING:	DATE OF REPORT

ADDRESS OF PERSON REPORTING:	TELEPHONE NUMBER OF PERSON REPORTING:
	SIGNATURE: (SCDHHS Representative Receiving Report)

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Provider ID:

NPI:

Recipient ID:

Adjustment Type:

◯ 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: _____

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Physicians
Sample Claim Showing TPL Payment
With NPI

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ( ) (Medicare #) | MEDICAID (x) (Medicaid #) | TRICARE CHAMPUS ( ) (Sponsor's SSN) | CHAMPVA ( ) (Member ID#) | GROUP HEALTH PLAN (x) (SSN or ID) | FECA BLK LUNG ( ) (SSN) | 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. PATIENT STATUS: Single ( ) Married ( ) Other ( ) | Employed ( ) Full-Time Student ( ) Part-Time Student ( )

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: A123450A

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

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

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: | SEX: M ( ) F ( )

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME: 22.00

c. OTHER ACCIDENT? YES ( ) NO (x)

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME: 401

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO ( ) *If yes*, return to and complete item 9 a-d.

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:

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 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. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 250 00 3.

2. 4.

22. MEDICAID 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 20 07	01 20 07	11		99213			35 00	1		ZZ	1212121212
														NPI	1234567890
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 | SSN ( ) EIN (x)

26. PATIENT'S ACCOUNT NO.: DOE1234

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

28. TOTAL CHARGE: $ 35 00

29. AMOUNT PAID: $ 22 00

30. BALANCE DUE: $ 13 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

Jane Smith, MD
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

Sample Remittance Advice (page 1)

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

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

AB00080000 | SOUTH CAROLINA MEDICAID PROGRAM | REMITTANCE ADVICE | 02/14/2014 | 1

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

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL". IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT	MEDICAID PG TOT
$0.00	$286.46

CERTIFIED AMT	MEDICAID TOTAL
	0.00

CHECK TOTAL

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

CHECK NUMBER

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 2)

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

PROVIDER ID. AB00080000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE 02/28/2014

PAGE 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	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 13047112536704 30A 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 $0.00

MEDICAID PG TOT $286.46

CERTIFIED AMT

MEDICAID TOTAL 0.00

CHECK TOTAL

CHECK NUMBER

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.

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 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

CERTIFIED AMT: 0.00

TO BE REFUNDED IN THE FUTURE: 0.00

ADJUSTMENTS: $193.71-

CHECK TOTAL: $50.00

CHECK NUMBER: 4197304

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	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	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	0.00

ADJUSTMENTS	CHECK TOTAL	CHECK NUMBER
-4338.95	0.00	

YOUR CURRENT DEBIT BALANCE: 0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

HEALTHY MOTHERS, HEALTHY FUTURES

Maternity Health Education Checklist

PATIENT'S NAME: _____

INSTRUCTIONS: This format provides for written documentation of providing health education to Medicaid maternity patients and suggests the range of topics that generally would be provided.

TOPIC	COMPLETED	DATE(S)
OFFICE SERVICES AND ROUTINES: Information about hours, appointments, lab tests, and other general procedures.	☐	_____ _____
GENERAL INSTRUCTION ABOUT PREGNANCY: such as hygiene, exercise, sexuality, medication, and importance of prenatal care.	☐	_____ _____
FETAL GROWTH AND DEVELOPMENT: how the baby develops month by month and physical and psychological changes experienced by the mother; including comfort measures.	☐	_____ _____
NUTRITION: including routine prenatal diet instruction. **(Be sure to make referral to WIC PROGRAM)**	☐	_____ _____
EXPLANATION OF EDC: Understanding the due date.	☐	_____ _____
DANGER SIGNS OF PREGNANCY: recognizing the warning signs and signifigance and risk of each; including specific instructions on what to do, who to contact and where to go in an emergency.	☐	_____ _____
RISKY BEHAVIORS: smoking, alcohol, substance use and abuse the risks, consequences to baby and methods for avoiding risks. **NOTE: Possible referral for smoking cessation or substance abuse**	☐	_____ _____
PROCESS OF LABOR AND DELIVERY: discussion of physical process of labor and delivery, including psychological changes experienced.	☐	_____ _____
METHODS OF ANESTHESIA: Information on types of anesthesia with discussion of benefits, risks and alternatives; also pain medication.	☐	_____ _____
CESAREAN SECTION: discussion of what it is and what are the usual indications including risks and benefits	☐	_____ _____
RELAXATION AND BREATHING EXERCISES: preparation for labor including demonstration and practice of exercises and breathing techniques	☐	_____ _____
BREASTFEEDING: factors to consider in decision making and preparation of the breasts **Note: Possible referral to La Leche or Breastfeeding Support**	☐	_____ _____

(Continued on Reverse)

MATERNITY EDUCATION CHECKLIST (Continued)

		DATE(S)	
PREPARATION OF OTHER FAMILY MEMBERS: sibling preparation and needs of other family members before and after birth of child; father suppport and involvement.	☐	_____	_____
DELIVERY ARRANGEMENTS: Hospital tours, expectations and procedures during delivery and hospital stay.	☐	_____	_____
POSTPARTUM CARE: Immediate postpartum needs and six weeks check-up and physical care at home, including psychological needs and adjustments.	☐	_____	_____
FAMILY PLANNING: Importance of family planning; risks of short inter-conceptional period and discussion of all methods.	☐	_____	_____
INFANT CARE AND PARENT EDUCATION: Routine infant care needs including preventive care, safety, expectations for infant development and provision for infant health care provider. Note: possible EPSDT referral.	☐	_____	_____
OTHER: Note special areas covered	☐	_____	_____

REFERRAL:

☐ WIC PROGRAM: Date: _____

☐ HRCP (if applicable)
High Risk Channeling Project Date: _____

☐ OTHER

_____ Date: _____

_____ Date: _____

SIGNATURE: _____

ATTENDING PHYSICIAN

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.

ADMA 9/20/90
SCCADA FORM

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 abd 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 DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

PEDIATRIC SUB-SPECIALISTS CERTIFICATION FORM

SECTION 1: PHYSICIAN DEMOGRAPHIC INFORMATION (*PLEASE PRINT*)		
Name (First, Middle, Last):		NPI#:
Physical Location Address:		Suite/Unit #:
City:	State:	ZIP+4:
E-mail Address:		
Telephone Number:		Fax Number:
Mailing Address (if different from physical location address):		
City:	State:	ZIP+4:

SECTION II: ATTESTATION STATEMENT

Beginning February 1, 2006, the monies appropriated for pediatric physician sub-specialists shall only be available to a physician who: **A)** in his/her medical practice, has at least 85% of their patients who are children 18 years or younger and **B)** practices in one of the following sub-specialties or other pediatric sub-specialty area as may be determined by the Department of Health and Human Services:

PEDIATRIC SUB-SPECIALTIES (CHECK ALL THAT APPLY)

☐ Adolescent Medicine	☐ Emergency Medicine	☐ Nephrology	☐ Pulmonology
☐ Allergy	☐ Endocrinology	☐ Neurology	☐ Radiology
☐ Cardiology	☐ Gastroenterology/Nutrition	☐ Neurological Surgery	☐ Rheumatology
☐ Cardiothoracic Surgery	☐ Genetics	☐ Ophthalmology	☐ Surgery
☐ Child Abuse Pediatrics	☐ Hematology/Oncology	☐ Orthopedic Surgery	☐ Urology
☐ Critical Care	☐ Infectious Disease	☐ Otolaryngology	
☐ Developmental-Behavioral Pediatrics	☐ Neonatology	☐ Psychiatry	

CERTIFICATION

I hereby certify that:

1. I am a physician member in good standing on the medical staff of a hospital.
2. I am qualified in and practice in the pediatric specialty noted in Section II above.
3. At least 85% of my total practice, including after-hours patients, is dedicated to children age 18 years and under.

Patient Heading	As a Group	As an Individual	TOTAL
Number of patients seen			
Number of MediCAID patients			
Number of patients 18 and under			
Number of patients with MediCAID 18 and under			

ATTESTATION/ASSURANCES AND SIGNATURE

I am providing this attestation certificate to the South Carolina Department of Health and Human Services with the request that I be included on the list of pediatric specialists eligible for enhanced reimbursement for selected services provided to children enrolled in the South Carolina Medicaid program. I hereby certify, under penalty of perjury, that the information provided on this certificate is correct as of the date of this certificate.

Physician Signature: Date:

CONTACT PERSON INFORMATION

Contact Person Name (please print):	Contact Email Address:
Contact Telephone Number:	Contact Fax Number:

Please ***FAX*** or ***MAIL*** completed/signed form to:
Medicaid Provider Enrollment
FAX: 803-870-9022
MAIL: POB 8809. Columbia. SC 29202-8809

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.

Form Approved: OMB No. 0937-0166
Expiration date: 7/31/2028

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 _____ (*Doctor or Clinic*). When I first asked 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 _____ (*Specify Type of Operation*). The discomforts, risks 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 _____ (*Specify Type of Operation*). My 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:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ 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 _____ (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation _____ (*Specify Type of Operation*), the fact that it is 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 _____ (*Name of Individual*) on _____ (*Date of Sterilization*) I explained to him/her the nature of the sterilization operation _____ (*Specify Type of Operation*), the fact that it is 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]

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.

Revised: 06/01/12

SOUTH CAROLINA MEDICAID PROGRAM
REQUEST FOR PRIOR APPROVAL REVIEW BY KEPRO

PATIENT NAME _____
LAST FIRST MI

BIRTHDATE _____ ***MEDICAID#** _____
MONTH/DAY/YEAR

PROCEDURE _____ CODE _____

DX CODE:_____

FACILITY _____ _____
NAME NPI #

PLANNED SURGERY DATE _____

*TO AVOID THE RISK OF NON–PAYMENT, PROVIDERS SHOULD CHECK ELIGIBILITY OF RECIPIENT PRIOR TO REQUEST FOR PRIOR APPROVAL REVIEW. IF THE RECIPIENT IS MANAGED CARE, PRIOR APPROVAL MUST BE OBTAINED THROUGH THE MANAGED CARE PROVIDER.

PHYSICIAN'S NAME _____
LAST FIRST MI

ADDRESS _____

_____ NPI: _____

CONTACT PERSON _____ TELEPHONE (_____) _____

DATE _____ FAX NUMBER (_____) _____

- **OFFICE NOTES DOCUMENTING THE REQUESTED INFORMATION MUST BE ATTACHED**
- **ALL PERTINENT DOCUMENTATION FOR THE PROCEDURE SHOULD BE MAILED TOGETHER**
- **PROVIDERS WILL BE NOTIFIED OF DETERMINATION VIA MAIL**

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE

Revised: 06/01/12

State of South Carolina
Department of Health and Human Services

Please return signed original certificate to:

Mailing Address:
SC Dept. of Health and Human Services
Behavioral Health Services
Post Office Box 8206
Columbia, South Carolina 29202-8206
Fax: (803) 255-8204

Section I: Demographic Information

Please Print:

Supervising Clinician Name:	
Address:	
Telephone:	
National Provider Identifier Number (NPI)	
Fax:	
Email:	

Section II: Allied Professional Update Form

The Licensed Master Social Workers (LMSW) listed below are under my supervision and services rendered and billed to South Carolina Medicaid will be in compliance with the guidelines as provided in the South Carolina Medicaid Physicians and other Medical Professions Manual

LMSW Name (as it appears on their license):	
License Number & Expiration Date:	
LMSW Name (as it appears on their license):	
License Number & Expiration Date:	
LMSW Name (as it appears on their license):	
License Number & Expiration Date:	

Should there be changes to this list, the professional's qualifications, and/or licensure, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply may result in the recoupment for services rendered. All allied professionals must be listed each time this form is submitted and a maximum of three allied professionals are permitted.

I hereby certify, that the information provided in the certificate is correct as of the date of this certificate.

Physician Signature _____ Date _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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

Send to:	Date:	# of Pages (including cover):
SCDHHS Bureau of Provider and Support Services Attn: Out-of-State Coordinator Fax: 803-255-8255	**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: _____

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 prior approval from SCDHHS are mandatory prior to the broker arranging travel. Hotel accommodations are for outpatient services *only*. 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				
REQUIRED *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.

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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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**

South Carolina
Department of Health and Human Services
Mental Health Form

FILL OUT COMPLETELY TO AVOID DELAYS

Beneficiary Information	
Beneficiary's Name:	
Medicaid ID #:	
Date of Birth:	

Provider Information	
Individual NPI:	
Organization NPI:	
Service Location Address:	
City & State:	

DSM-IV TR Diagnosis

Axis I _____/_____/_____ Axis II _____/_____ Axis III _____/_____

Date first seen: _____ **Date of last service:** _____ **# of additional visits requested:** _____

Current Clinical Information: (Circle each. Scale 0=None, 1=Mild, 2=Moderate, 3=Severe, 4=Extreme)

Aggression	0 1 2 3 4	Depressions	0 1 2 3 4	Relationship Problems	0 1 2 3 4
Alcohol/Substance Use	0 1 2 3 4	Hallucinations	0 1 2 3 4	Side Effects	0 1 2 3 4
Anxiety/Panic	0 1 2 3 4	Impulsivity	0 1 2 3 4	Sleep Effects	0 1 2 3 4
Appetite Disturbance	0 1 2 3 4	Job/School Problems	0 1 2 3 4	Sleep Disturbance	0 1 2 3 4
Attention/Concentration	0 1 2 3 4	Mania	0 1 2 3 4	Weight Loss	0 1 2 3 4
Deficit in ADLs	0 1 2 3 4	Medical Illness	0 1 2 3 4	Other	0 1 2 3 4
Delusions	0 1 2 3 4	Memory	0 1 2 3 4	Current Stressors	0 1 2 3 4

Services

◇ 90833 ◇ 90846 ◇ 90853 ◇ 90837

◇ 90836 ◇ 90847 ◇ 90832 ◇ 96102

◇ 90838 ◇ 96101 ◇ 90834

Current Medications	**Name**	**Dose**	**Frequency**	**Side Effects**
◇ **New**	**1.**			
◇ **New**	**2.**			
◇ **New**	**3.**			
◇ **New**	**4.**			

Compliance ◇ **>90%** ◇ **50-90%** ◇ **<50%**

Reasons for Noncompliance:	

_____ (___)_____ (___)_____

Physician Name Phone: Fax

_____ _____

Physician Signature Date

Clinical documentation must be submitted with this request and submitted to the QIO using one of the following methods:
KePRO FAX#: 1-855-300-0082, KePRO Customer Service Phone#: 1-855-326-5216, KePRO website: http://scdhhs.Kepro.com.

Disclaimer: Authorization indicates that SCDHHS determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility and benefit limitations at the time services are rendered. The Physician Assistant is not authorized to sign this form.

Behavioral Health Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

SOUTH CAROLINA MEDICAID PROGRAM
PSYCHIATRIC PRIOR AUTHORIZATION

*TO AVOID THE RISK OF NON-PAYMENT, PROVIDERS SHOULD CHECK ELIGIBILITY OF RECIPIENT PRIOR TO REQUEST FOR PRIOR APPROVAL REVIEW. IF THE RECIPIENT IS MANAGED CARE, PRIOR APPROVAL MUST BE OBTAINED THROUGH THE MANAGED CARE PROVIDER.

FAX TO: KePRO 1-855-300-0082

DATE: _____

PATIENT NAME: _____ MEDICAID #: _____
LAST FIRST MI

BIRTH DATE: _____ INPATIENT _____ OUTPATIENT _____
MONTH/DAY/YEAR

PRIMARY DX: (CIRCLE ONE→) OPPOSITIONAL DEFIANCE DISORDER OR CONDUCT DISORDER

DX CODE(S): _____

PLANNED ADMISSION DATE: _____

HOSPITAL: _____ _____
NAME MEDICAID ID #

INFORMATION NEEDED (PLEASE CIRCLE ALL INCLUDED):

HISTORY & PHYSICAL:

OFFICE NOTES - PCP AND/OR SPECIALIST

PREVIOUS TREATMENTS:

MEDICATION

CURRENT CLINICAL NOTES DOCUMENTING THE REASON FOR ADMISSION INCLUDING ABOVE INFORMATION MUST BE ATTACHED

PHYSICIAN'S NAME: _____ _____
LAST FIRST MI MEDICAID PROVIDER ID #:

ADDRESS: _____

CONTACT PERSON: _____ PHONE #: _____

SOUTH CAROLINA MEDICAID PROGRAM
CIRCUMCISION
REQUEST FOR PRIOR APPROVAL REVIEW

SEND COMPLETED REQUEST FORM WITH MEDICAL RECORDS TO:

SCDHHS
CIRCUMCISION PRIOR APPROVAL REVIEW
FAX: (803) 255-8255

PATIENT NAME _____
LAST FIRST MI

BIRTHDATE _____ *MEDICAID# _____
MONTH/DAY/YEAR

PROCEDURE _____ CODE _____

DX CODE:_____

FACILITY _____ _____
NAME NPI #

PLANNED SURGERY DATE _____

*TO AVOID THE RISK OF NON–PAYMENT, PROVIDERS SHOULD CHECK ELIGIBILITY OF RECIPIENT PRIOR TO REQUEST FOR PRIOR APPROVAL REVIEW. IF THE RECIPIENT IS MANAGED CARE, PRIOR APPROVAL MUST BE OBTAINED THROUGH THE MANAGED CARE PROVIDER.

PHYSICIAN'S NAME _____
LAST FIRST MI

ADDRESS _____

_____ NPI: _____

CONTACT PERSON _____ TELEPHONE (_____) _____

DATE _____ FAX NUMBER (_____) _____

- **OFFICE NOTES DOCUMENTING THE REQUESTED INFORMATION MUST BE ATTACHED**
- **ALL PERTINENT DOCUMENTATION FOR THE PROCEDURE SHOULD BE MAILED TOGETHER**
- **PROVIDERS WILL BE NOTIFIED OF DETERMINATION VIA FAX**

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE

Revised: 02/01/11

SOUTH CAROLINA Healthy Connections MEDICAID

SBIRT INTEGRATED SCREENING TOOL

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina

*** Fax the COMPLETED form to the patient's plan and referral site and keep a copy in patient file**

☐ Absolute Total Care Fax: 877-285-3226	☐ BlueChoice HealthPlan Medicaid Fax: 855-580-2810	☐ Molina Fax: 866-423-3889	☐ Wellcare Fax: 866-455-6562
☐ Advicare Fax: 888-781-4316	☐ First Choice by Select Health Fax: 866-533-5493	☐ SCDHHS (Fee-For-Service) Fax: 803-255-8247	☐ BlueCross BlueShield of South Carolina & BlueChoice HealthPlan Fax: 803-870-9884

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Language:	Race:	Ethnicity:	Expected due date:
Phone no: ( )	Street address:		Member ID no:			

PROVIDER INFORMATION

Practice name:	Group NPI:	Individual NPI:	Screening provider's name:	Phone no: ( )

PATIENT SCREENING INFORMATION

Parents Did any of your parents have a problem with alcohol or drug use?	○ YES				○ NO
Peers Do any of your friends have a problem with alcohol or other drug use?	○ YES				○ NO
Partner Does your partner have a problem with alcohol or other drug use?			○ YES		○ NO
Violence Are you feeling at all unsafe in any way in your relationship with your current partner?		○ YES			○ NO
Emotional Health Over the last few weeks, has worry, anxiety, depression or sadness made it difficult for you to do your work, get along with people or take care of things at home?				○ YES	○ NO
Past In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?			○ YES		○ NO
Present In the past month, have you drunk any alcohol or used other drugs? 1. How many **days per month** do you drink? _____ 2. How many **drinks** on **any given day**? _____ 3. How often did you have **4 or more drinks per day** in the last **month**? _____ 4. In the past month have you taken any prescription drugs?			○ YES		○ NO
Smoking Have you smoked any cigarettes in the past three months?			○ YES		○ NO
Please provide additional details for any "yes" responses:	↓ Review risk	↓ Review domestic violence resources	↓ Review substance use, set healthy goals	↓ Consider mental evaluation	

ADVICE FOR BRIEF INTERVENTION

	Y	N	N/A
Did you **S**tate your medical concern?			
Did you **A**dvise to abstain or reduce use?			
Did you **C**heck patient's reaction?			
Did you **R**efer for future assessment?			

At Risk Drinking	
Non-Pregnant	**Pregnant/Planning Pregnancy**
7+ drinks/week 3+ drinks/day	**Any Use is Risky Drinking**

CONFIDENTIAL SBIRT REFERRAL INFORMATION

Patient referred to: (Check all that apply)	☐ DMH	☐ DAODAS	☐ DHEC Quitline Fax: 800-483-3114	☐ Private provider (Name & NPI)	☐ Domestic violence 803-256-2900
Date of referral appointment (DD/MM/YY):	Date screened:	☐ Patient refused referral	☐ Referral not warranted		☐ Patient requested assistance

Women's health can be affected by emotional problems, alcohol, tobacco, other drug use and domestic violence. Women's health is also affected when those same problems are presented in people close to us. By "alcohol," we mean beer, wine, wine coolers or liquor.

Physician's Signature: _____

**Adapted from Institute for Health & Recovery, (2015)*

Universal 17-P Authorization Form

*Fax the COMPLETED form OR call the plan with the requested information.

☐Absolute Total Care	☐BlueChoice HealthPlan	☐First Choice by Select Health	☐WellCare Health Plan, Inc.
P: 803-933-3689 F: 866-918-4451	P: 866-902-1689 F: 800-823-5520	P: 888-559-1010 x55251 F: 866-533-5493	P: 888-588-9842 F: 866-458-9245

☐Advicare	☐Molina Healthcare, Inc.
P: 888- 781-4371 F: 888- 781-4316	P: 855- 237-6178 F: 855- 571-3011

Date of Request for Authorization _____

Patient/Member Name _____ DOB _____
First Middle Last

Address (Street, Apt.#) _____ City/State/Zip _____

Phone _____ Medicaid Number _____ MCO ID Number _____

☐Pregnancy Information and History

G___ T ___ P___ A ___ L ___ (Note: A= abortion (spontaneous and medically induced) EDC _____

Last menstrual period _____ EDD _____ Current Gestational age _____ weeks

Bed Rest ☐Yes ☐No Experiencing Preterm Labor ☐Yes☐ No
(Home administration available if on bed rest)

☐Singleton Pregnancy ☐Multiple Pregnancy

At least 16 weeks gestation ☐Yes ☐No** Major Fetal or Uterine Anomaly ☐Yes ☐No

Patient has a history of prior spontaneous singleton preterm birth between 20-36.6 weeks ☐Yes ☐No

Delivery was due to preterm labor or PPROM even if it resulted in C-section ☐Yes ☐No

Delivery was not due to medical indication, e.g. preeclampsia, abruption, etc. ☐Yes ☐No

Medication Allergies _____ ☐No known drug allergies

Other Pertinent Clinical Information: _____

☐Pharmacy Information

☐Ship to patient's home address End Date of Service _____

☐Ship to provider's address End Date of Service _____

Shipping Preference: ☐Regular Mail ☐Ground ☐Overnight

Ordering Physician's Signature: _____ Makena or 17-P Compound _____

☐Provider Information

Ordering Provider Name _____
(Please Print)

Ordering Provider NPI _____ Tax ID _____

Address _____ City/State/Zip _____

Phone _____ Fax _____

Provider Type: ☐OB/GYN ☐Family Medicine ☐MFM/Perinatology ☐Other

Practice Name: _____ Practice NPI: _____

Contact Person: _____ Phone: _____ Fax: _____

FOR MCO USE ONLY:

☐Approved ☐Denied Authorization # _____ Number of Injections _____

Date of Notification to Provider: _____ Reviewer(s) name & title: _____

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.

** Prescription may be written prior to 16 weeks, but the vial shipment may be withheld by the pharmacy until the 15th week

SCDHHS Behavioral Health Referral & Feedback Form

Physician Referral for Licensed Independent Practitioner Services

Date: _____ ( ) Initial ( ) Follow-up

Referring Physician Name: _____

Address: _____
(Street/PO Box) City State Zip

Fax: (___) _____ Phone: (____) _____

Patient's Name: _____ DOB: _____

Parent's Name (if minor): _____ Address: _____ Phone: _____

Date(s) Patient Seen: _____

Reason(s) for Referral: _____

_____

Any Specific Questions or Requests: _____

_____

_____
Referring Physician's Printed Name/Signature

Thank you for evaluating this patient. To facilitate communication and treatment, please make copies of the following form to retain in the patient's record; complete a form after initial assessment; complete additional forms periodically during treatment (as indicated) and when treatment is terminated; and mail or fax completed form(s) to the physician listed above. This is not a request for copies of psychotherapy notes, which require a signed consent to release. Thank you for your collaboration.

Licensed Independent Practitioner's Report

Date(s) Patient Seen: _____

- ❑ Patient did not make appointment.
- ❑ Patient made an appointment but did not keep appointment.
- ❑ Patient not seen within 60 days.

Initial Diagnoses:

1. _____
2. _____
3. _____

Recommendations: _____

_____

Medications Prescribed: _____

_____

Follow-up Arranged or Provided by Consultant:

- ❑ Further diagnostic testing _____
- ❑ Individual psychotherapy
- ❑ Family psychotherapy
- ❑ Medication management
- ❑ Group psychotherapy
- ❑ Lab tests
- ❑ Return visit _____

Other Care Needed:

- ❑ Medication management by PCP
- ❑ Referrals recommended _____
- ❑ Follow-up recommended _____
- ❑ Other: _____

_____
Name (type or print) Signature

FAX to _____
Contact Person

Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Form: Beneficiary Informed Consent for Hereditary Cancer Genetic Testing

Instructions: Prior authorization request for BRCA 1 and BRCA 2 genes and BRCA Analysis Rearrangement testing for breast and ovarian cancer must be submitted to KEPRO. The Hereditary Breast and Ovarian Cancer Genetic Testing Prior Authorization Form must be completed and signed as outlined in the instructions below. The completed form with the original dated signature must be retained by the requesting physician in the beneficiary's medical record. The form is subject to retrospective review.

The following forms, documents, and information must be submitted with the prior authorization request to KEPRO:

- ☐ The completed and signed Hereditary Breast and Ovarian Cancer Genetic Testing Prior Authorization Form
- ☐ Medical necessity documentation, including documentation of the efforts made to obtain the test results of previous comprehensive sequencing when appropriate
- ☐ Attestation for comprehensive testing. The attestation must indicate that familial BRCA testing results could not be obtained (as necessary).

Providers can refer to the South Carolina Department of Health and Human Services Physician Services Guide on the website at www.scdhhs.gov for specific information about coverage guidelines, prior authorization requirements and billing guidance.

Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Form: Beneficiary Informed Consent for Hereditary Cancer Genetic Testing

Section A: Beneficiary Information	
Name:	
Medicaid ID#:	Date of birth:

Section B: Requested procedure or service information

Check one:

☐ This request is for initial BRCA 1 and BRCA 2 testing.

☐ This request is for repeat BRCA 1 and BRCA 2 comprehensive sequencing testing because initial results are negative, or are not available, and large rearrangement testing is necessary. **Note:** The physician must make every reasonable effort to obtain from the previous physician any available BRCA 1 and BRCA 2 test results for the beneficiary and must submit documentation of the efforts made to obtain the test results of previous comprehensive sequencing to KEPRO with the prior authorization request.

Expected dates of service **From:** **To:**

Procedure code requested	**Procedure code description**

Comments:

Section C: Medical necessity information – Submit clinical notes to support genetic testing request.

Diagnosis code(s):

Medical necessity:

Information about close blood relatives from the same side of the family who have been diagnosed with ovarian, breast, prostate (Gleason score of 7 or greater), or pancreatic cancer, or who have had a positive BRCA1 or BRCA2 test results with no diagnosis of cancer:

Relative	a. Age	b. Gender	c. Cancer	d. Relationship to Beneficiary	e. Positive BRCA1 or BRCA2 Results
Relative #1:					
Relative #2:					
Relative #3:					
Relative #4:					

For full sequence or gene variants: Positive familial BRCA testing results could not be obtained	☐ Yes ☐ No

Ethnic decent of beneficiary if associated with deleterious mutations (including, but not limited to: Ashkenazi Jewish, Icelandic Swedish, or Hungarian):

Physician's name:	
Telephone number:	Fax number:
Physician's NPI:	Facility/Office NPI:
Physician's signature:	Date signed:

Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Form: Beneficiary Informed Consent for Hereditary Cancer Genetic Testing

Section D: Requirements for genetic counseling and beneficiary consent – The beneficiary must receive pre-testing genetic counseling and provide consent for genetic testing before the prior authorization is submitted and the blood specimen is obtained. Documentation of the genetic counseling must be maintained in the beneficiary's medical record.	
Date the beneficiary receive pre-testing genetic counseling:	
Name of person who provided pre-testing genetic counseling:	
Qualifications of person providing pre-testing genetic counseling:	
Counselor telephone number:	Counselor fax number:
Date beneficiary's consent was obtained for the genetic testing:	
Section E: Laboratory provider information	
Provider name:	
Address/City/Zip	
Contact person:	
Telephone number:	Fax number:
NPI:	Tax ID:

Pharmacogenetic Genetic Testing Prior Authorization Request Form
KEPRO-SCDHHS QIO

KEPRO-SCDHHS QIO now requires any Medicaid Provider submitting Prior Authorizations using their National Provider Identifier (NPI) with their 9 digit zip code. If you do not know your 9-digit zip code then please visit: http://zip4.usps.com/zip4/welcome.jsp

Submit fax request for Prior Authorization to: 1-855-300-0082
Requests may be submitted up to 30 days prior to scheduled procedures/services, provided Member is eligible.

1. Date of Request (mm/dd/yyyy)	**2. Review Type (check one if applicable)** ☐ Prior Authorization ☐ Retrospective Prepayment Review (Date notified of eligibility:			
3. **Member Medicaid ID Number** (10-digit Number):	4. **Member Last Name**:	5. **Member First Name:**	6. **Date of Birth** (mm/dd/yyyy):	7. **Gender:** ☐ Male ☐ Female
8. **a. NPI/Requesting Service Provider Name & ID Number:** **b. 9-digit Zip Code (Mandatory)**	9. **Treatment Setting** ☐ Outpatient LAB		10. **Primary Diagnosis Code: (enter up to 5)** 1. 2. 3. 4. 5.	
11. **a. NPI/Rendering Provider Name and ID Number:** **b. 9-digit Zip Code (Mandatory)**	12. **Prior Auth Service Type:** ☐ LAB	**CPT CODE:** ☐ 81418		
13. **NPI/ORDERING Provider Name and ID Number:**				

14. Contact Name:
15. Contact Telephone Number:
16. Contact Fax Number:

**Please submit this form in addition to the medical records that support the genome testing. This may include H&P, current treatment plan and medications.

Pharmacogenetic Genetic Testing Prior Authorization Request Form
KEPRO-SCDHHS QIO

INSTRUCTIONS FOR OUTPATIENT ELECTRONIC FAX FORM

This FAX submission form is required for faxed Pharmacogenetic testing Reviews. When submitting the fax, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being denied or returned via FAX for additional information.

If KEPRO determines that your request meets appropriate coverage criteria guidelines, the Prior Authorization (PA AUTH) number provided by KEPRO will be provided to you via Fax back process and will be available to providers registered on the web-based program Atrezzo (https:portal.kepro.com). **This excludes weekends and holidays.**

1. **Date of Request:** The date you are submitting the Prior Authorization request.
2. **Review Type:** Place a √ or **X** in the appropriate box. Requests must be received on or before services are rendered. Please refer to the Provider Manuals regarding Retrospective review policy and procedure for detailed information regarding the services being requested. If retrospective eligibility, enter the date that the provider was notified of retrospective eligibility.
3. **Member Medicaid ID Number:** It is the provider's responsibility to ensure the Member's Medicaid number is valid. This should contain 10 digits
4. **Member Last Name:** Enter the Member's last name exactly as it appears on the Medicaid card.
5. **Member First Name:** Enter the Member's first name exactly as it appears on the Medicaid card.
6. **Date of Birth**: Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).
7. **Gender:** Please place a √ or **X** to indicate the sex of the member.
8. **a. NPI Requesting /Service Provider Name and ID Number:** Enter the requesting/service provider name and National Provider Identifier (NPI).

   b. 9-digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI number being submitted.
9. **Treatment Setting:** Default to OUTPATIENT/ LAB
10. **Primary Diagnosis Code /Description:** Provide the primary diagnosis code and/or description indicating the reason for service(s).
11. **a. NPI Rendering Provider Name and ID Number:** Enter the rendering provider name and National Provider Identifier (NPI) for the provider performing the service.

    b. 9-digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI number being submitted,
12. **Prior AUTH Service Type and Procedure Code:** This request for is specifically for Pharmacogenetic Testing, CPT 81418
13. **NPI Ordering Provider:** must be a board-certified psychiatrist or psychiatrist extender
14. **Contact Information** Please put the name and contact number of the person completing the request so we may contact you if we have any questions

**** Reminder: Prior Authorization is based on medical necessity and is not a guarantee of payment. Providers are responsible for checking patient eligibility and following the rules and regulations outlined in the SCDHHS provider policy and billing manuals.**