Healthy Connections South Carolina Department of Health and Human Services

Notice of Admission, Authorization & Change of Status for Long Term Care



Detailed

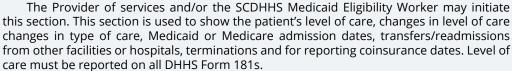
Instructions

DHHS FORM 181 is utilized by Nursing Facilities (NF's), Intermediate Care Facilities For Individuals with Intellectual Disability (ICF/IID's), Swing-Bed Hospitals (SB's), and/or SCDHHS Medicaid Eligibility Workers. The DHHS FORM 181 is authorization by the Department of Health and Human Services for payment and reimbursement for NF, ICF/IID, and SB services rendered to the eligible patient. A separate form must be prepared for each eligible patient receiving Provider Services. A DHHS FORM 945 should accompany all retroactive determinations over one year old for eligibility or recurring income.

A. Section I - Identification of Provider and Patient:

This section is self-explanatory and will be completed in its entirety by the originating party. Please note the "HIB" suffix (Health Insurance Benefit code) of the Social Security Claim Number under item 7. This suffix (either alpha, numeric or both) relates specifically to Medicare qualifying beneficiaries, indicating benefits under Medicare, Title XVIII (Medicare Identification Card). The Provider information must be completed. This form will not be processed without the correct Medicaid ID of the recipient and the correct provider number.

B. Section II - Type of Coverage and Statistical Data:



For Authorization, send Form 181 to: SCDHHS Central Mail PO Box 100101 Columbia, SC 29202

If the recipient has a non-covered medical expense, complete Forms 235 and 236. Send completed forms, if applicable, to: SCDHHS Division of Policy and Planning

PO Box 8206 Columbia, SC 29202-8206.

C. Section III - Authorization and Change of Status:

Only the SCDHHS Medicaid Eligibility Worker is responsible for the completion of this section. The SCDHHS Medicaid Eligibility Approval Authority/Supervisor or a SCDHHS authorized representative must sign and date each form for all new admissions, income changes, and discharges home that affect income liability.



Co-Insurance

In the case of filing for Medicare Coinsurance, a SNF Authorizing DHHS FORM 181 must be completed for each Medicare spell of illness. Coinsurance periods are billed using a copy of the initial signed authorization. Coinsurance dates must be supported by EOMBs; must not cross a calendar month; and the service dates must be consecutive.

The coinsurance authorization expires if the spell of illness is broken or after 80 days of coinsurance, whichever comes first. Coinsurance claims cannot be added to the monthly billing. **NOTE:** Effective with dates of service 12/01/01, DHHS no longer reimburses nursing facilities or ICFs/IID for Part A SNF coinsurance. Swing Bed Hospitals are paid coinsurance. **Coinsurance claims should never be sent with the monthly billing.**



The Provider of services will normally initiate these forms. The SCDHHS Medicaid Eligibility Worker initiates them for all income changes and certain terminations. The Provider of services must forward the forms to the appropriate SCDHHS Medicaid Eligibility Worker only when signature authorization in Section III is required.

A. Copy
Copy
Original

A. Copy
Submitted by Provider for claims processing at MCCS.
Retained and kept on file by SCDHHS Medicaid Eligibility.
Retained and kept on file by the Provider of services.

B. The Provider of services must attach a copy of this form to the current month's billing for each change in the status of a patient. Staple all 181 forms together for each patient.

Mailing address for end of month claims: MEDICAID CLAIMS RECEIPT - NF CLAIMS SECTION

POST OFFICE BOX 100122

COLUMBIA, SOUTH CAROLINA 29202-3122

Overnight delivery address: MCCS-NF-AW-220

CLAIMS RECEIPT - NF CLAIMS SECTION

8901 FARROW ROAD COLUMBIA, SC 29203 -8930

DHHS Form 181 (April 2014)...



Notice of Admission, Authorization, and Change of Status for Long Term Care

Must Be Typed or Completed in Blue or Black Ink

Hospice enrolled on or before admission: \square

				<u> </u>
	ovider and Patient (Completed			
1. Beneficiary Name (First, Middle, Last)		2.Birth Date (MO-DY-YY)	3. Medicaid No. (10 digits)	
4. Facility Name		6.County of Residence	7. Social Security No HIB Su	ffix
,		,		
5. Facility Street Addres	S			
		8.Provider Medicaid ID	9. Date of Request	
City	State ZIP			
•				
10. Authorized Represer	ntative's Name	12. Authorized Represe	entative's Street Address	
		·		
11. Authorized Representative's Phone No.		City	State	ZIP
11. Authorized Represei	ittative s Phone No.	City	State	ZIF
Section II. Type of Coverage a	and Statistical Data			
		HECK APPLICABLE BOX AND COM	PLETE)	
	-	CARE (LOC2) SNF COINSURAN	*	
(R) CHANGE IN TYPE OF	CARE: FROM	TO	DATE:	
(C) ADMITTANCE DATE F	OD:		<i>DNIE</i>	
(D) TRANSFERRED				
• •		MO-DY-YY	NAME OF OTHER FACILITY	
(E) READMITTED FROM H	HOSPITAL STAY:			
		COVERED DAYS:		
(G) TERMINATION DATE	:	DATE OF DEATH	RETURNED HOME (NO	OTIFY ELIGIBILITY)
(H) COINSURANCE DATE	S THIS BILL FROM	THROUGH	NO. OF DAYS:	MO-DY-YY
		FORM 2		
			T=ky	
(J) ACTION:				
ACTION:		DATES OF SERVICE:	T=ky	
COMMENTS:				
Section III. Authorization and	Change of Status (Completed	by DHHS EEMS Only)		
14. Recommendation of	SCDHHS Medicaid Eligibil	lity Worker (Check Applicable E	Boxes and Complete)	
(A) Authorization to Reg	in Date: (B) A	pplicant Not Qualified for long	torm care because	
			l Allowance) \$	
-		ess Personal Allowance) \$	TAllowance) \$	
(E) Income Trust? (Checl			MO-DY-YY	
	N			
(F) Other				
Section IV Signature				
Section IV- Signature				
Name of Eligibi	lity Worker (Print)	Eligibility Worke	er Signature	Date