Healthy Connections

South Carolina Department of Health and Human Services

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

things to know

General Information

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.**

Detailed Instructions

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:

The Provider of services and/or the SCDHHS Medicaid Eligibility Worker may initiate this section. This section is used to show the patient's level of care, changes in level of care changes in type of care, Medicaid or Medicare admission dates, transfers/readmissions from other facilities or hospitals, terminations and for reporting coinsurance dates. Level of care must be reported on all DHHS Form 181s.

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.**

Distribution, Preparation and Routing of Form

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 — Submitted by Provider for claims processing at MCCS.
Copy — Retained and kept on file by SCDHHS Medicaid Eligibility.
Original — 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

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Must Be Typed or Completed in Blue or Black Ink

Hospice enrolled on or before admission: ☐ (Check if Yes)

Section I. Identification of Provider and Patient (Completed by Provider/Facility)

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 Suffix
5. Facility Street Address	8.Provider Medicaid ID	9. Date of Request
City / State / ZIP		
10. Authorized Representative's Name	12. Authorized Representative's Street Address	
11. Authorized Representative's Phone No.	City / State / ZIP	

Section II. Type of Coverage and Statistical Data

13. INITIAL COVERAGE AND/OR CHANGE IN STATUS (CHECK APPLICABLE BOX AND COMPLETE)

(A) ☐ SKILLED CARE (LOC1) ☐ INTERMEDIATE CARE (LOC2) ☐ SNF COINSURANCE (MEDICARE LOC6)

(B) CHANGE IN TYPE OF CARE: FROM Choose One TO Choose One DATE: _____

(C) ADMITTANCE DATE FOR: Choose One DATE: _____

(D) TRANSFERRED From Choose One _____ (MO-DY-YY) _____ (NAME OF OTHER FACILITY)

(E) READMITTED FROM HOSPITAL STAY: _____ (MO-DY-YY)

(F) NUMBER OF DAYS ABSENT FROM FACILITY: _____ COVERED DAYS: _____

(G) TERMINATION DATE: _____ DATE OF DEATH _____ (MO-DY-YY) ☐ RETURNED HOME (NOTIFY ELIGIBILITY)

(H) COINSURANCE DATES THIS BILL FROM _____ (MO-DY-YY) THROUGH _____ (MO-DY-YY) NO. OF DAYS: _____ (MO-DY-YY)

(I) NON-COVERED MEDICAL EXPENSE: AMOUNT: _____ ☐ FORM 236 ATTACHED

(J) ACTION: Choose One DATES OF SERVICE: _____ T I W ¦ _____

ACTION: Choose One DATES OF SERVICE: _____ T I W ¦ _____

COMMENTS:

Section III. Authorization and Change of Status (Completed by DHHS EEMS Only)

14. Recommendation of SCDHHS Medicaid Eligibility Worker (Check Applicable Boxes and Complete)

(A) Authorization to Begin Date: _____ (B) Applicant Not Qualified for long term care because: Choose One

(C) Beneficiary's Initial Applicable Recurring Income (Total Income Less Personal Allowance) $ _____

(D) Change in Beneficiary Income (Total Income Less Personal Allowance) $ _____ _____ (MO-DY-YY)

(E) Income Trust? (Check) ☐

(F) Other

Section IV– Signature

Name of Eligibility Worker (Print)	Eligibility Worker Signature	Date