Division of Children's Health
Children and Youth with Special Health Care Needs (CSHCN) Program

AUTHORIZATION

The person named below has been determined eligible for receipt of specified services, supplies, equipment or medications for DHEC reimbursement. Fees and terms available at www.scdhec.gov/health/mch/ch/cshcn

AUTHORIZED RECIPIENT

LAST Name

FIRST Name

Date of Birth MCI #

Diagnosis

Private Insurance ☐ If this box is checked: (1) Request for DHEC reimbursement MUST include documentation of amount paid by insurance, denial, or EOB). (2) Reimbursement for medications limited to prescription co-pay amount

Medicaid ☐ No ☐ Yes Medicaid #

AUTHORIZATION

VALID DATES From To

Date(s) of service on invoice must fall within valid period for DHEC reimbursement. Contact issuing DHEC office if service not completed before authorization expires.

CSHCN Service

Authorization Date

Authorizing Official Name

Authorizing Official Signature

Form completed by:

AUTHORIZED SERVICE(S)

Additional approval required if cost for single item or prescription is $2,500 or more. Contact issuing DHEC office before purchasing or dispensing.

AUTHORIZED PROVIDER *(person or entity that will deliver the service)*

Name

Address

City, State, Zip

Phone

ISSUING DHEC OFFICE

PAYEE / VENDOR INFORMATION *(for authorized provider)*

Vendor Number

Vendor Name

Vendor Address

Provider (or designee) signature below confirms that information contained in this request for payment, invoice, CMS1450 or CMS1500 is true, accurate, and complete; and that authorized services were provided in accordance with applicable laws, regulations, professional practice standards, and/or DHEC guidance. Signature indicates that the provider:

- Will accept DHEC payment as payment in full (fee schedules and reimbursement rate information available on website.)
- Will bill Medicaid, private insurance or other third party sources of payment before billing DHEC, accept reimbursement limited to the amount remaining after payment by third parties, and refund DHEC if third party payment is received after DHEC reimbursement.
- Will seek additional approval from issuing office if cost of a single item or prescription is $2,500 or more.
- Will submit request for reimbursement as soon as possible, and no later than 12 months, after completion of authorized service to assure DHEC payment.
- Will comply with applicable DHEC contractual terms and conditions posted on website and available from the issuing DHEC office, or by contacting the CSHCN Program office at 803-898-0784.

PROVIDER SIGNATURE _____ Date _____

SIGN, ATTACH INVOICE (and INSURANCE EOB if applicable), and RETURN TO ISSUING DHEC OFFICE

Authorization number

To be completed by issuing DHEC office

Regional review of invoice(s) submitted for authorized services

Date invoice received _____

No	Yes		No	Yes	
☐	☐	Attached authorization was issued before date of service*	☐	☐	Invoice received within 12 months of date of service*
☐	☐	Services provided before authorization expiration date*	☐	☐	Required supporting documentation attached*
☐	☐	Pharmacy Bill Summary attached			

(* Justification/explanation required if "NO".)

COMMENTS

Signature _____ Date _____

To be completed by CSHCN Program office

Data entered by _____

Data entry date _____ **Total Approved for DHEC Payment** $ _____

Service Date	Procedure Code Auth Units/Days	Billed Units / Days	Organization	Fund	Account	Activity	Amt paid by insurance	Amt paid by DHEC

Comments