South Carolina Department of Health & Human Services

REFERRAL FORM / AUTHORIZATION FOR REHABILITATIVE SERVICES

FORM **254**

(1) **NATIONAL PROVIDER IDENTIFIER #**

(2) **BENEFICIARY'S MEDICAID #**

(3) REFERRED TO: _____

(4) AUTHORIZATION DATE: _____

EXPIRATION DATE: _____ (Last Date of Service)

(5)

Name	County	Address			
Date of Birth	Sex	Agency Reference No.	City	State	Zip

(6)

Prior Authorization Number (1st two letters reflect the agency's origin. Remaining 5 characters are left up to referring agency or SCDHHS QIO.)	Parent/ Guardian

The provider named above is hereby authorized to render the following service(s) on or within the designated time period for the Medicaid-eligible beneficiary which is not to exceed12 months. The number of units and staff to provide services should be based on the medical needs of the beneficiary and from the referral source. Please refer to the Rehabilitative Behavioral Health Service Provider Manual for Modifiers and Procedure codes. Only the number of units authorized may be billed.

(7)

			Procedure Code	Modifier	Unit	Total Units Authorized	Frequency
	Assessment Services						
1		Behavioral Health Screening	H0002		15 minutes		
2		Diagnostic Assessment – Initial	90801		Per Encounter		
3		Diagnostic Assessment – Follow up	99213		Per Encounter		
4		Psychological Testing / Evaluation	96101	AH	60 minutes		
5		Comprehensive Evaluation – Initial	H2000		Per Encounter		
6		Comprehensive Evaluation – Follow up	H0031		Per Encounter		
7		Alcohol & Drug Assessment – Follow up	H0001		Per Encounter		
	Treatment Plan Development and Modification Services						
8		Service Plan Development (Mental Health)	H0032		15 minutes		
9		Service Plan Development (Team w/ Client	99366		15 minutes		
10		Service Plan Development (Team w/o Client)	99367		15 minutes		
	Therapy Services						
11		Individual	90804		30 minutes		
12		Group	90853		30 minutes		
13		Family w/o client	90846		30 minutes		
14		Family w/ client	90847		30 minutes		
	Community Support Services						
15		Crisis Management	H2011		15 minutes		
16		Medication Management	H0034		15 minutes		
17		Rehab Psychosocial Service *	H2017		15 minutes		
18		Behavior Modification (BMod) *	H2014		15 minutes		
19		Family Support *	S9482		15 minutes		
20		Peer Support*	H0038		15 minutes		

*Service(s) not authorized by the SCDHHS QIO.

Authorizing Agency: (One must be marked)

(8)

_____ Department of Social Services
_____ Department of Mental Health
_____ Continuum of Care For Emotionally Disturbed Children
_____ Department of Disabilities and Special Needs
_____ Department of Juvenile Justice
_____ School District / Department of Education
_____ United Way
_____ SCDHHS Quality Improvement Organization

(9)

Authorized Agency Representative _____

Title _____

Phone _____

Signature _____

Date _____

State Agency Use Only:

DHHS Form 254 (Revised 08/2010) Original – Provider Copy – Referring State Agency Copy – SCDHHS State Office

254 Form Instructions

Follow the instructions below to complete the 254 form. This form can only be obtained from the Department of Health and Human Services. Only the referring agency can request a copy of the 254 form.

1. **National Provider ID Number:** This is a 10-digit number that is retrieved from the provider who will be administering the services. This number is required to bill Medicaid.
2. **Beneficiary's Medicaid Number:** The Medicaid number of the person who will be receiving the services.
3. **Referred to:** The provider's name and address.
4. **Authorization/Expiration Date:** This is the date that the service is authorized to begin and end. The expiration date cannot exceed a year from the authorization date.
5. Personal information of the person who will be receiving the services.
6. **Prior Authorization Number:** This seven-digit number is retrieved from the agency who is referring the services.

   Note: For school districts, the first two characters of the prior authorization number are ED; then the next two characters are their school district's identification number from the **State Department of Education**. (This is not the same as the district's code number.) The remaining three digits can be chosen by the district. **It is very important that the correct prior authorization number is used. If you are unsure of your district's Prior Authorization Number, please contact your representative at the State Department of Education.**
7. In this section, designate the amount of services the provider will be allowed to provide.

   Note: School districts need to be aware that they will be charged the match fee from the State Department of Education; therefore, closely monitor the number of units being designated as the school district will be responsible for paying the fee.
8. **Authorizing Agency:** Mark which agency is referring the service.
9. **Authorized Agency Representative:** The agency representative who signs the form should be a person who is able to make decisions on behalf of the agency. Ideally there should only be one person who signs this form in the entire agency. This person should know the purpose of this form and have some system in place to monitor the number of referrals being made.