State of South Carolina
Department of Social Services

Supplemental Benefits Medical Reimbursement Request

For any questions related to this form please contact DSS State Office Adoptions at 803 898 3956 or qaadoptionmedicalcoverage@dss.sc.gov

Complete form legibly, include proof of expenditures, and mail to SC DSS, State Office Adoption Services, PO BOX 1520, Columbia, SC 29202, or email to supplementalreimbursementrequests@dss.sc.gov.

SECTION A: Basic Information (complete by Provider or Adoptive Parent)

Child's Name: (Last, First, MI)	Date of Birth	Adoptive Family Name	DSS Tracking Number
Payee's Name	Payee's Phone	Payee's Email	
Payee's Address			

SECTION B: Prior Approval (not needed for children 17 and younger for respite)

For Children 18-20 years old respite care	For Professional Services	Is this State Office Adoption Representative Approved?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No (DSS verifies this information.)
What is this approved for?		

SECTION C: Respite (for a child(ren) 18-20 medical necessity letter required)

Who (name of person)	Amount paid $	
Date Range 1: from to	Date Range 2: from to	Date Range 3: from to

SECTION D: Professional Services

Note: If you are a new professional services provider, then a completed Form W-9 and a Request for Taxpayer ID and Certification must be completed and returned, which can be obtained from Adoption Services.

Provider or Therapist Name	Payee's Federal ID or Social Security No.:	Professional Services Signature: (if paying provider)

Type of Service	Dates of Service	Total Cost	Less Insurance	Balance
		$	$	$
		$	$	$
		$	$	$
		$	$	$
Documentation: (Original bill, or copy if original not available, must be attached.)			**Total Payment Amount:**	$

SECTION E: Adoptive Family Certification

I certify that the above services were provided on behalf of this child.

Adoptive Family's Signature	Date

SECTION F: SC DSS ONLY

State Office Adoptions Representative: ☐ Approved or ☐ Denied

State Office Adoption Representative Signature:	Date: