



## Best Chance Network Document Verification Checklist

The Best Chance Network (BCN) program require each applicant to show proof of identification, residence (address), and income to determine if they are eligible for services. Please read the following statement before completing this form.

**I certify under penalty of perjury that the information I have provided as an authorized, contracted provider for Best Chance Network (BCN) medical services has been obtained and verified. I understand the information I provide will be used to determine the patient's eligibility for Best Chance Network (BCN) medical services. I understand that as a contracted provider of these services, SC Department of Public Health (SC DPH) can audit or request any eligibility or supporting documents, to verify that the patient meets the eligibility requirements.**

<b>Completion of this form is to verify</b> (check all that apply and then circle the documents used in the below lists):	<input type="checkbox"/> 1. Income	<input type="checkbox"/> 2. Residency	<input type="checkbox"/> 3. Identification & age	<input type="checkbox"/> 4. Health Insurance (Medicaid, Medicare, other)
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**1. To verify income/family size**

- Statement of income/family size
- Employer statement
- Social Security/VA statement
- Retirement benefits
- Self-employment statements
- Check stubs
- Child support statement/check

**2. To verify residency (30 consecutive days in state):**

- Statement of SC residency (employer; neighbor, other)
- Driver's license
- State ID
- Mail
- Voter's registration card
- School or work identification

**3. To verify identification:**

- Driver's license
- State ID
- Passport
- US Citizenship and Immigration document (visa)

**4. To verify health insurance status:**

- Statement of Insurance Status
- Copy of insurance card
- Explanation of Benefits
- Employer statement of insurance status

Staff Signature: _____	Date: _____
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Interpreter Name: _____	Name: _____
Date: _____	DOB: _____
Time: _____	SS#: _____

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**Explanation:** The purpose for this form is to create a record of the documents used to verify Best Chance Network identification, residency, family income, or health insurance coverage.

**Instructions:**

**I Understand Block:** The provider reads and understands the certification statement.

**Completion of this form is for:** Check the specific area (s) for which the applicant is providing documents. (All four reasons may be circled)

**To verify:** Provider circles the documents used.

**Staff Signature:** Interviewing provider staff member signs their name and enters the date.

**Office Use Only Box:** Attach a participant label or write the participant's name, DOB and last four of social security number.

**Office Mechanics:** The original Document Verification Checklist should be filed in the medical record with BCN documents for that date of service. Retain this signed form in the medical record for six years after the contract expiration date. BCN records shall be available for audit.

**If Interpretive Services are required:**

\* Staff serving applicants requiring interpretative services will contact their interpreter. The applicant will speak with the interpreter and the interpreter will translate the information to the provider staff. A copy of the Spanish Document Verification Checklist form will be provided for Spanish speaking applicants to review during the interpretation process.

**Interpreter Name:** Staff documents interpreter name.

**Time:** Staff documents time services are performed.

**Date:** Staff documents date services are performed.