DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	5/15/09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 101645	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Emma Forkew Cleared 6/9/09, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 5/27/09 [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

May 12, 2009

To Whom It May Concern:

Enclosed you will find information pertaining to my failure in health. I need to have emergency surgery on my teeth to have three taken out of my mouth. These teeth are messing with my health as I am asking ~~to~~ to appeal a decision on a medical service that I need to have done. I had a bad seizure years

ago and I broke both of my jaws. I then had to be hospitalized until they came back into place; after they put braces on my teeth and used rubber bands to help pull my jaws back into place. Since they took the braces off my teeth, they has been falling out piece by piece at a time. I need to get three surgically

taken out before my
health goes down for
bad. Please reconsider
and help me get this
done as soon as possible.

Thank you
&
Respectfully
Ms. Jordan Pearson

Palmetto Dental Health Assoc.
103 East Tatum Avenue
McColl, SC 29570

Office Phone: 843-523-5291

Julia Pearson
202 South St
Bennettsville, SC 29512

Treatment Proposal
extraction of teeth
Prepared for Julia Pearson

Printed on 05-08-09 at 12:09p

The fees in this proposal are valid until 06-07-09. After that, fees may increase.

Visit #1

Code	Description	T#	Surface	Fee	You pay
07210	Surgical Extraction	1		222.00	222.00
07210	Surgical Extraction	15		222.00	222.00
07210	Surgical Extraction	21		222.00	222.00
	TOTAL			666.00	666.00

← one tooth at a time

Patient signature: X _____

Palmetto Dental Health Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, Julia A. Pearson, have received a copy of this office's Notice of Privacy Practices.

Julia Ann Pearson
Please Print Name

Julia A. Pearson
Signature

May 8, 2009
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

CareSouth Carolina Referral Form

Date: 4/20/09 Chart Number: _____

If Minor:

Patient Name: Julia Pearson (Parent or Guardian Name) _____

Address: 202 South Street _____ Home# (___) ___-____
City State Zip

DOB: 1/18/53 SSN: ___-___-____ Work# (___) 862 6122

Referral To: Dentist / Palmetto Dental Office# (843) 523 5291

Address: _____ Fax# (___) ___-____
City State Zip

Referring Physician Name: Thomas Referring Physician Signature: [signature]

Referring Physician NPI#: _____ Referring Physician Authorization#: _____

Reason for Referral: _____

_____

_____

Records / Documents to be Sent: (Check All That Apply) ☒Medication List **(REQUIRED ON ALL REFERRALS)**

Medication List also provided to patient via: ☐ **Personal** ☐ **Mail** ☐ **Other:** _____

☐ Progress Note From date: _____ to _____ ☐ Labs from date: _____ to _____

☐ X-ray(s) of: _____

☐ Other: _____

Patients Insurance Type: (Primary) _____ (Secondary) _____

Insurance Precert # (If Required): _____ Dates Precert Valid Thru: _____ to _____

Verifying Personnel Name @ Insurance Company: _____

Patients Appointment Scheduled For: Day Friday Date: 4/24/09 Time 9:00 AM/PM

Patient Instructions: 10 minutes earlier

Patient Directions to Referred Physician Office (If Needed): 5-8-09 @ 1100

A 24 HOUR NOTICE OF CANCELLATION IS REQUESTED

*****If you are unable to keep this medical appointment, please notify the doctor you have been referred to, or your CareSouth Carolina medical center, so that your appointment may be rescheduled. *********

****Attention Referred Specialist/Hospital/MRI Center/ETC. ****

Please Send All Consultation Reports/Test(s)/Lab(s) etc. back to the (√) information provided below.

☐**Bishopville Center** 545 Sumter Hwy PO Box 508 Bishopville, SC 29010 PH:803.484.5317 FAX:803.484.4533	☐**Hartsville Center** 1268 South 4th St PO Box 909 Hartsville, SC 29550 PH:843.332.3422 FAX:843.332.3985	☐**Cheraw Center** 212 Third St PO Box 1357 Cheraw, SC PH:843.537.0961 FAX:843.537.0908	☐**Rosa Lee Gerald** 737 South Main St PO Box 239 Society Hill, SC 29593 PH:843.378.4501 FAX:843.378.4209	☐**Lake View Center** 103 North Kemper St PO Box 1076 Lake View, SC 29565 PH:843.759.2189 FAX:843.759.2180
☐**Bennettsville Center** 999 Cheraw St PO Box 1197 Bennettsville, SC 29512 PH:843.479.2341 FAX:843.479.2346	☐**Bennettsville Pediatrics** 210 West Main Street PO Box 1076 Bennettsville, SC 29512 PH:843.479.1200 FAX: 843.479.1230:	☐**McColl Center** 225 South Main St PO Box 86 McColl, SC 29570 PH:843.523.5751 FAX:843.523.6040	☐**Hunt Family Practice** 106 Hospital Square PO Box 508 Bishopville, SC 29010 PH:803-484-5943 FAX:803.484.6975	☐**Chesterfield Center** 500 W. Boulevard PO Box 346 Chesterfield, SC 29709 PH:843.623.5080 FAX:843.623.5081

4 Medical History cont.

Your current physical health is ☐ Good ☑ Fair ☐ Poor

Are you currently under the care of a physician? ☐ No ☐ Yes

Please explain _____

Are you taking any prescription / over-the-counter drugs? ☐ No ☑ Yes

Please list each one (Cara South Has Info.

For Women: Are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant? ☑ No ☐ Yes Week # _____

Are you nursing? ☑ No ☐ Yes

Have you ever had any of the following diseases or medical problems?

Y ~~N~~	Heart Attack / Stroke	Y N	Psychiatric Problems
Y ~~N~~	Cancer / Chemotherapy	~~Y~~ N	Epilepsy / Seizures / Fainting Spells
Y ~~N~~	Heart Murmur	Y ~~N~~	Diabetes / Tuberculosis (TB)
Y ~~N~~	Rheumatic Fever	~~Y~~ N	Drug / Alcohol Abuse
Y ~~N~~	HIV+ / AIDS	Y ~~N~~	Venereal Disease
Y ~~N~~	Heart Surgery / Pacemaker	Y ~~N~~	Hemophilia / Abnormal Bleeding
Y ~~N~~	Shingles	~~Y~~ N	Ulcers / Colitis
Y ~~N~~	Mitral Valve Prolapse	Y ~~N~~	Congenital Heart Defect
Y ~~N~~	Kidney Problems	~~Y~~ N	Anemia / Radiation Treatment
Y ~~N~~	Artificial Bones / Joints	~~Y~~ N	Asthma / Arthritis
Y ~~N~~	Artificial Valves	~~Y~~ N	Difficulty Breathing
Y ~~N~~	Sinus Problems	~~Y~~ N	Hospitalized for Any Reason
~~Y~~ N	High / Low Blood Pressure	Y ~~N~~	Hepatitis
~~Y~~ N	Fever Blisters	Y ~~N~~	Blood Transfusion
~~Y~~ N	Severe / Frequent Headaches	Y ~~N~~	Emphysema / Glaucoma

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following drugs?

Y ~~N~~	Penicillin	Y ~~N~~	Tetracycline	Y ~~N~~	Latex
Y ~~N~~	Aspirin	Y ~~N~~	Dental Anesthetics	Y N	Other
Y ~~N~~	Erythromycin	Y ~~N~~	Codeine		

Please list any other drugs that you are allergic to: _____

5 Dental History

Why have you come to the dentist today? To have X Rays

Are you currently in pain? ☑ No ☐ Yes

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ No ☑ Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ No ☑ Yes

Your current dental health is ☐ Good ☑ Fair ☐ Poor

Do you like to smile? ☐ No ☑ Yes Do your gums ever bleed? ☐ No ☑ Yes

How many times a week do you floss? ___ a day do you brush? 1

Type of bristles? ☐ Hard ☑ Medium ☐ Soft

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. I understand that as a courtesy to me my insurance will be filed, but that I am financially responsible for any amount not paid by my insurance company after a period of 60 days.

Signature Barbara M. Carson Date May 8, 2007

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials _____ Date _____

Doctor's Comment: _____

MEDICAL HISTORY UPDATE

1. Date _____ Comments _____ Signature _____
2. Date _____ Comments _____ Signature _____
3. Date _____ Comments _____ Signature _____

```
1EDHMS54-P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 05/15/09
 MEDSPROD                      RECIPIENT INFORMATION               ACTION:
                    MEMBER PERIOD START: 12/20/08  END:            PAGE: 0001
 NAME: PEARSON JULIA                                HH NAME: PEARSON JULIA
 RCP NUMBER: 1780951202      HH NUMBER: 101302751    ACTION TYPE: MAINTENANCE
 SSN: 240-92-7573  VC: V     APL STATUS:             ACTION DATE: 11/25/08
 PRIMARY INDIVIDUAL:         APL CO: 35    WORKER ID: TCOZI    LOCATION: 055
 202 SOUTH STREET                          SSCN: 240927573A    RRN:
                                           RACE: 02   SEX: F   MARITAL STATUS: U
                                           TPL: Y     RSP: 0   RELATION: SELF
 BENNETTSVILLE               SC 29512-     DOB: 01/18/1953     DOD:
 CORRECT RCP NUMBER: _____                 LIV ARRANGEMENT: HOME INCOME TRUST:
                                           PROVIDER:
      BG       BEG         END                BENEFITS QMB RETRO  % OF POV
S  NUMBER     ELIG        ELIG     PCAT QCAT   TYPE     IND  IND    LEVEL    SPONSOR
_ 20378204 01/01/2009              48   50    LIMITED    N    N      1.21      9955



 UPDATED: USER ID: TCOZI      DATE: 11/25/08  SYSTEM ID: TTR1001  DATE: 12/24/08
ME900063 RECIPIENT RECORD FOUND
 PF2->HH BG  PF3->HH MBR DTL  PF4->REFH  PF5->ELD02  PF6->RETURN  PF7->PREV
 PF8->NEXT  PF9->HH NOTES  PF15->RCP SEARCH  PF17->ELD00  PF18->HH MBR BGS
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Complete Letter RM

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers / Hamilton	5/15/09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 001545	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Emma Forkenu	[X] Prepare reply for appropriate signature DATE DUE 5/21/09 [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. Shirley Carrington Dept. Head	6-8-09		
2. Beverly Hamilton	6/8/09 Bev		
3.			
4.			

RECEIVED
MAY 18 2009
BUREAU OF CARE MANAGEMENT

May 12, 2009

To Whom It May Concern:

Enclosed you will find information pertaining to my failure in health. I need to have emergency surgery on my teeth to have three taken out of my mouth. These teeth are messing with my health so I am asking ~~to~~ to appeal a decision on a medical service that I need to have done. I had a bad seizure years

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health goes down too
bad. Please reconsider
and help me get this
done as soon as possible.

Thank you
&
Respectfully
Ms. Jordan Pearson

Palmetto Dental Health Assoc.
103 East Tatum Avenue
McColl, SC 29570

Office Phone: 843-523-5291

Julia Pearson
202 South St
Bennettsville, SC 29512

Treatment Proposal
extraction of teeth
Prepared for Julia Pearson

Printed on 05-08-09 at 12:09p

The fees in this proposal are valid until 06-07-09. After that, fees may increase.

Visit #1

Code	Description	T#	Surface	Fee	You pay
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07210	Surgical Extraction	21		222.00	222.00
	TOTAL			666.00	666.00

← one tooth at a time

Patient signature: X _____

Palmetto Dental Health Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, Julia A. Pearson, have received a copy of this office's Notice of Privacy Practices.

Julia Ann Pearson
Please Print Name

Julia A. Pearson
Signature

May 8, 2009
Date

For Office Use Only

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- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

CareSouth Carolina Referral Form

Date: 4/20/09 Chart Number: _____

Patient Name: Julia Pearson If Minor: (Parent or Guardian Name) _____

Address: 202 South Street _____ Home# (___) ___-____
City State Zip

DOB: 1/18/53 SSN: ___-___-____ Work# (___) 862-6122

Referral To: Dentist / Palmetto Dental Office# (843) 523-5291

Address: _____ Fax# (___) ___-____
City State Zip

Referring Physician Name: Thomas Referring Physician Signature: TOT

Referring Physician NPI#: _____ Referring Physician Authorization#: _____

Reason for Referral: _____

Records / Documents to be Sent: (Check All That Apply) ☒Medication List **(REQUIRED ON ALL REFERRALS)**

Medication List also provided to patient via: ☐ **Personal** ☐ **Mail** ☐ **Other:** _____

☐ Progress Note From date: _____ to _____ ☐ Labs from date: _____ to _____

☐ X-ray(s) of: _____

☐ Other: _____

Patients Insurance Type: (Primary) _____ (Secondary) _____

Insurance Precert # (If Required): _____ Dates Precert Valid Thru: _____ to _____

Verifying Personnel Name @ Insurance Company: _____

Patients Appointment Scheduled For: Day Friday Date: ~~4/24/09~~ Time ~~9:00~~ AM/PM

Patient Instructions: 10 minutes earlier

Patient Directions to Referred Physician Office (If Needed): 5-8-09 @ 1100

A 24 HOUR NOTICE OF CANCELLATION IS REQUESTED

*****If you are unable to keep this medical appointment, please notify the doctor you have been referred to, or your CareSouth Carolina medical center, so that your appointment may be rescheduled. *********

****Attention Referred Specialist/Hospital/MRI Center/ETC. ****

Please Send All Consultation Reports/Test(s)/Lab(s) etc. back to the (√) information provided below.

☐**Bishopville Center** 545 Sumter Hwy PO Box 508 Bishopville, SC 29010 PH:803.484.5317 FAX:803.484.4533	☐**Hartsville Center** 1268 South 4th St PO Box 909 Hartsville, SC 29550 PH:843.332.3422 FAX:843.332.3985	☐**Cheraw Center** 212 Third St PO Box 1357 Cheraw, SC PH:843.537.0961 FAX:843.537.0908	☐**Rosa Lee Gerald** 737 South Main St PO Box 239 Society Hill, SC 29593 PH:843.378.4501 FAX:843.378.4209	☐**Lake View Center** 103 North Kemper St PO Box 1076 Lake View, SC 29565 PH:843.759.2189 FAX:843.759.2180
☐**Bennettsville Center** 999 Cheraw St PO Box 1197 Bennettsville, SC 29512 PH:843.479.2341 FAX:843.479.2346	☐**Bennettsville Pediatrics** 210 West Main Street PO Box 1076 Bennettsville, SC 29512 PH:843.479.1200 FAX: 843.479.1230:	☐**McColl Center** 225 South Main St PO Box 86 McColl, SC 29570 PH:843.523.5751 FAX:843.523.6040	☐**Hunt Family Practice** 106 Hospital Square PO Box 508 Bishopville, SC 29010 PH:803-484-5943 FAX:803.484.6975	☐**Chesterfield Center** 500 W. Boulevard PO Box 346 Chesterfield, SC 29709 PH:843.623.5080 FAX:843.623.5081

Palmetto Dental Health Associates P.A.
103 East Tatum Avenue
McColl, SC 29570
(843) [illegible]-5290

WELCOME

The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please take a few minutes to complete these forms completely. The better we communicate the better [illegible]

1 About You

Today's Date: May 8, 2009

Name: Julia Ann Pearson

I prefer to be called: Julia ☐ Male ☑ Female

Birthday: 01/18/53 Age: 57 SS #: 240-92-7573

Home Address: 202 South Street

Bonnetsville, S.C. 29512
CITY STATE ZIP APT / CONDO #

☑ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: _____ Pager / Other #: 862-6122

WK #: _____ Ext ____

Employer: Home Applicant

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Who may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 Spouse Information

Their Name: _____

Employer: _____

WK #: _____ Ext ____ SS #: _____

Birthday: _____

Person Responsible for Account: _____

WK #: _____ Ext ____ HM #: _____

Billing Address: _____

Relationship: _____ SS #: _____

ZIP

Employer: _____

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: __/__/__ Insured's SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: __/__/__ Insured's SS #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____ Relation: _____

WK #: _____ HM #: _____

4 Medical History

Do you have a personal physician? ☐ No ☐ Yes

Physician's Name: _____

Phone #: _____ Date of last visit: _____

CONTINUED ON BACK OF FORM

4EDHMS54 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 05/15/09
MEDSPROD RECIPIENT INFORMATION ACTION:
MEMBER PERIOD START: 12/20/08 END: PAGE: 0001

NAME: PEARSON JULIA HH NAME: PEARSON JULIA
RCP NUMBER: 1780951202 HH NUMBER: 101302751 ACTION TYPE: MAINTENANCE
SSN: 240-92-7573 VC: V APL STATUS: ACTION DATE: 11/25/08
PRIMARY INDIVIDUAL: APL CO: 35 WORKER ID: TCOZI LOCATION: 055
202 SOUTH STREET SSCN: 240927573A RRN:
RACE: 02 SEX: F MARITAL STATUS: U
TPL: Y RSP: 0 RELATION: SELF
BENNETTSVILLE SC 29512- DOB: 01/18/1953 DOD:
CORRECT RCP NUMBER: _____ LIV ARRANGEMENT: HOME INCOME TRUST:
PROVIDER:

S	BG NUMBER	BEG ELIG	END ELIG	PCAT	QCAT	BENEFITS TYPE	QMB IND	RETRO IND	% OF POV LEVEL	SPONSOR
_	20378204	01/01/2009		48	50	LIMITED	N	N	1.21	9955

UPDATED: USER ID: TCOZI DATE: 11/25/08 SYSTEM ID: TTR1001 DATE: 12/24/08
ME900063 RECIPIENT RECORD FOUND
PF2->HH BG PF3->HH MBR DTL PF4->REFH PF5->ELD02 PF6->RETURN PF7->PREV
PF8->NEXT PF9->HH NOTES PF15->RCP SEARCH PF17->ELD00 PF18->HH MBR BGS

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

June 9, 2009

Ms. Julia Pearson
202 South Street
Bennettsville, South Carolina 29512

Dear Ms. Pearson:

Thank you for your letter regarding your need for dental services. As Ms.Shirley Carrington explained during your conversation today, we are the agency for Medicaid services and she believed you were trying to reach the Medicare office. Since you are not enrolled in the Medicaid program, we are unable to assist in providing the dental services that you requested. You can call your county eligibility office for assistance in determining whether you can be enrolled in the Medicaid program. The contact telephone number for the Marlboro eligibility office is (843) 479-4520.

If you have any further questions, please contact Ms. Carrington at (803) 898-2568.

Sincerely,

Felicity Myers, Ph.D.
Deputy Director

FM/hhc

Medical Services
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2501 Fax (803) 255-8235