

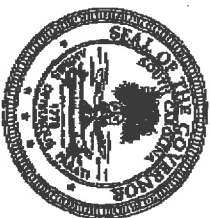
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Bowling</i>	DATE <i>5-7-07</i>
----------------------	-----------------------

DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER  <i>000709</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____		
2. DATE SIGNED BY DIRECTOR  <i>Cleared 5/17/07, e-mail response attached.</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>5-17-07</i> <input type="checkbox"/> FOIA DATE DUE _____ <input type="checkbox"/> 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.			



Log.  
"Rolling  
"app sign"

## State of South Carolina

Office of the Governor

MARK SANFORD  
GOVERNOR

OFFICE OF EXECUTIVE  
POLICY AND PROGRAMS

### FAX TRANSMITTAL COVER

DATE:	5/7/07
FAX TO:	Jan Polatty
FAX #:	898-4515
FROM:	Susanne Cooper 734-9873

Total number of pages:  
4  
(including this cover sheet)

If you have any problems receiving this document, please contact:

Jan, Brenda Williams  
RE: Ltr. from Linda Moss regarding Medicaid  
claim for her Aunt, Ms. Linda Moss. Are there  
any options for Ms. Moss?

Thank you!

Susanne Cooper

Office of Constituent Services  
Post Office Box 12267  
Columbia, SC 29211  
TELEPHONE: (803) 734-5049 • FAX: (803) 734-0789

(864) 839-6619

006312

Dear Mr. Doremus

4-17-07

I am writing this

letter in regard to medicaid.

My aunt is 65 years old DIRECTIVE  
and she has m8, she also

You recently fallen and  
broke your hip. They put you <sup>in</sup> ~~the~~  
in fracture center for rehab,

He was there for about

2 months, and now we have received a bill for

almost \$5500.00. It was  
sent as a certified letter,

So I went to the Post Office and got it. Medicaid said

they had sent 2 more letters before, but we have not seen them. How when I call them about it,

they tell me they can't  
pay because of it, bear  
more than 30 days old.

They also told me what they needed which was the proceed agreement

from the funeral home, I  
bald went and got that

and sent them a copy.

If you could help  
us with this or tell us  
what we can do, to get  
them to help pay this  
bill it would be greatly  
appreciated.

I have talked to  
Medicaid and the Parities  
Coten, and from what  
I can get from them,  
sounds like miscommunication  
between them and now  
it is costing my Aunt.

Thank You  
Very Much

My name: Brenda Williams  
Patient's name: Linda Moore

My address is: 1134 York Rd.  
Blackburg S.C. 29702

Please respond and again  
Thank You

Brenda Williams  
1134 York Rd.  
Blacksburg S.C.  
29702

CHARLOTTE NC 282

17 APR 2007 PM 4 T



Governor Mark Sanford  
Office of the Governor  
P.O. Box 12267  
Columbia, S.C.  
29211



05-07-2007

12:03pm

From-GOVERNOR SANFORD

CES

8037340386

T-546

P.004

F-373

05/07/2007 12:03PM

EDHMS54 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 05/07/07  
MEDSPROD MEMBER INFORMATION ACTION:

NAME: MOSS LINDA W HH NAME: MOSS LINDA W PAGE: 0001

RCP NUMBER: 2113266901 HH NUMBER: 100515199 ACTION TYPE: MAINTENANCE

SSN: 250-68-0321 VC: V APL STATUS: ACTION DATE: 02/09/07

PRIMARY INDIVIDUAL: APL CO: 11 WORKER ID: MATIW LOCATION: 001

131 E BELLS BRANCH RD SSCN: 250680321A RRN:

RACE: 01 SEX: F MARITAL STATUS: D

TPL INSURANCE: N RELATION: SELF

BLACKSBURG SC 29702-

DOB: 07/12/1941 DOD:

CORRECT RCP NUMBER: LIV ARRANGEMENT: NECL INCOME TRUST:

PROVIDER: PEACHTREE CENTRE

BG BEG END BENEFITS QMB RETRO % OF POV CHIP

S NUMBER ELIG ELIG PCAT QCAT TYPE IND IND LEVEL NUMBER

21132669 07/01/2002 32 50 .71

UPDATED: USER ID: VFOST DATE: 07/14/04 SYSTEM ID: TTR1001 DATE: 03/11/03  
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

106#709

**From:** Arnetta Harvey  
**To:** scooper@oepp.sc.gov  
**Date:** 5/17/2007 3:25 pm  
**Subject:** Inquiry concerning Linda Moss and Medicaid eligibility status

**CC:** Jan Polatty; Nicole Mitchell Threatt; Richard...  
Dear Ms. Cooper,

This communication is to update you regarding the inquiry from Brenda Williams concerning medicaid eligibility for Linda Moss.

We shared the inquiry with the division of medicaid eligibility. They investigated the case and found that Ms. Moss did qualify for Medicaid Nursing Home coverage. Eligibility will generate the appropriate documents and provide them to the nursing facility, which can then bill Medicaid appropriately.

I have contacted Ms. Brenda Williams and the nursing facility billing person, Sandra Hofeizer, and will work with the facility to get the billing completed. Ms. Williams has my contact information and will contact me if she has any additional concerns regarding this matter.

Please let me know if you have any questions,

Thank you,

Arnetta Harvey  
SCDHHS  
Department of Facility Services  
803.898.4615

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR**

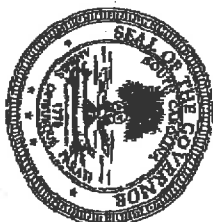
**ACTION REFERRAL**

TO <i>Bowling</i>	DATE <i>5-7-07</i>
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<b>DIRECTOR'S USE ONLY</b>	<b>ACTION REQUESTED</b>
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2. DATE SIGNED BY DIRECTOR _____	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>5-17-07</i>
	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

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





Log:  
"Positive  
"appears"

## State of South Carolina

Office of the Governor

MARK SANFORD  
GOVERNOR

OFFICE OF EXECUTIVE  
POLICY AND PROGRAMS

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Thank you!

Susanne Cooper

Office of Constituent Services  
Post Office Box 12267  
Columbia, SC 29211  
TELEPHONE: (803) 734-6049 • FAX: (803) 734-0789

(864) 839-6619 839.1819

1706312

4-17-07

Dear Mr. Claiborne

I am writing this

Letter in regard to medicid.

My aunt is 65 years old  
and she has 778, she also

APR 20 2007

has recently fallen and is referred to

**Referred to**

OR

broke her hip. They put plastered cast

in each tree center for 10 mby

she was there for about

2 reporting, and now we

Have received a bill for

abstract \$5500.00. at end

Sent as a certified letter,

So I went to the Post Office

and got it. Medicaid said

they had lost 2 more

letters before, but we have

not dear <sup>0</sup> thanks. Yours when

I call them about it,

they told me they can't

may because of it be

more than 30 days old.

They also told me what

they needed which was

The proposed Agreement

from the funeral home, &

Saloo went and got that

and sent them a copy.

if you could help  
us with this or tell us  
what we can do to get  
them to help pay this  
bill it would be greatly  
appreciated.  
I have talked to  
Medicaid and the Pachtree  
Center, and from what  
I can get from them,  
Mundo like miscommunication  
between them and now  
it is costing my Aunt.

Thank You

Very Much

My name: Brenda Williams  
Patient's name: Linda Moore

My address is: 1134 York Rd.

Blackburg S.C. 29702

Please respond and again  
Thank You

Brenda Williams  
1134 York Rd.  
Blacksburg S.C.  
29702

CHARLOTTE NC 282

17 APR 2007 PM 4 T



Governor Mark Sanford  
Office of the Governor  
P.O. Box 12267  
Columbia, S.C.  
29211



05-07-2007 12:03pm From-GOVERNOR SANFORD CES

8037340386

T-546 P.004 F-373

05/07/2007 12:03PM

EDHMS54 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 05/07/07  
MEDSPROD RECIPIENT INFORMATION ACTION:

NAME: MOSS LINDA W MEMBER PERIOD START: 02/17/07 END: PAGE: 0001

RCP NUMBER: 2113266901 HH NUMBER: 100515199 HH NAME: MOSS LINDA W ACTION TYPE: MAINTENANCE

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PRIMARY INDIVIDUAL: APL CO: 11 WORKER ID: MATIW LOCATION: 001

131 E BELLS BRANCH RD SSCN: 250680321A RRN:

BLACKSBURG SC 29702- RACE: 01 SEX: F MARITAL STATUS: D

CORRECT RCP NUMBER: LTV ARRANGEMENT: NFCL INCOME TRUST: TPL INSURANCE: N RELATION: SELF

DOB: 07/12/1941 DOD: PROVIDER: PEACHTREE CENTRE

BG	BEG	END	PCAT	QCAT	TYPE	IND	IND	LEVEL	NUMBER	
S	NUMBER	ELIG	ELIG	PCAT	QCAT	TYPE <td>IND</td> <td>IND</td> <td>LEVEL</td> <td>NUMBER</td>	IND	IND	LEVEL	NUMBER
21132669	07/01/2002	32	50							.71

UPDATED: USER ID: VF0ST DATE: 07/14/04 SYSTEM ID: TTR1001 DATE: 03/11/03  
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PF8->NEXT PF9->HH NOTES PF15->RCP SEARCH PF17->ELD00 PF18->HH MBR BGS

05/15/2007 09:32 0644872798

PAGE 01/04

**Cherokee County Long Term Care Facility**

d.b.a.

**Peachtree Centre**

1434 N. Limestone Street  
Guthrie, South Carolina 29340  
(864) 487-2717  
Fax (864) 487-2798

May 15, 2007

Arnetta Harvey  
DHHS  
Columbia, SC

Re: Linda Moss, Medicaid ID 2113266901

Ms. Linda W. Moss was admitted to Peachtree Centre's Rehabilitation Unit on October 24, 2006. On her 20th Medicare day, November 12, 2006, I sent a 181 coinsurance form to Mrs. Matilda Willie at Cherokee County's Medicaid Eligibility office. I did not mail this form, but hand delivered it, since their offices are in the same building as our Long Term Care Facility. Ms. Moss did need to fill out an application for nursing home Medicaid, so because Ms. Moss did not have any family to help her with this paperwork, I helped her to fill out the application needed. I was unable to gather any necessary additional paperwork since Ms. Moss was unable to travel to her home until her rehab was completed.

Ms. Moss was discharged on December 29, 2006 to her home. She left on this day, prior to the end of the month, so that she would not have a reoccurring income for the month of December, and would only owe for 18 days in November, 2006. (ie the month of discharge to home, the reoccurring income is zero ) I cannot be sure how many times during her stay I talked to Ms. Moss and Mrs. Willie about the status of her 181 form.

After Ms. Moss was discharged (within a week or two), I inquired about the status and was told by Mrs. Willie that there were still some forms to be filled out. Mrs. Willie sent the necessary paperwork to me via interoffice mail and I then forwarded the paperwork to Ms. Moss at home. I called her to let her know that she needed to fill out and sign everything and to get everything requested back to Medicaid Eligibility as soon as possible. Because Ms. Moss was unable to travel due to her chronic conditions, she sent the paperwork back to me, via her Home Health therapist who personally delivered it to me. I then immediately took the paperwork back to Mrs. Willie.



05/15/2007 09:35AM

05/15/2007 09:32 8644872798

PAGE 02/04

On February 8, 2007, Mrs. Willie returned my original 181 coinsurance form to me with a denial stating that "the client had not returned the needed information". I called Mrs. Willie to find out what she still needed, since we had returned the paperwork she had forwarded to Ms. Moss, and was told that there was a piece of information that Ms. Moss still needed to get for her. I called Ms. Moss and asked her to call Medicaid Eligibility to see what the information was and to please get that to her as soon as possible.

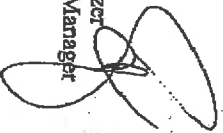
At the end of February, first of March, I generated a bill showing the coinsurance cost of \$119.00 per day from November 13, 2006 through December 28, 2006. This amounted to \$ 5,474.00 plus getting her hair done once, for a total cost of \$ 5,483.00. This is the amount due if her Medicaid nursing home coinsurance form is not returned to the facility to cover these days. If the form is completed and returned, Ms. Moss will only owe a portion of her social security check for the 18 days in November.

I sent a certified letter to Ms. Moss on April 2, 2007, again showing the above amount owed. Her caregiver, Brenda Williams, called me on April 13, 2007 to ask me what Ms. Moss needed to do and she would help her. I called her back and talked to Ms. Moss and told her that my hands were tied and that she needed to call Mrs. Willie at Medicaid Eligibility to find out what was needed to complete the facility's paperwork.

I have had no contact since then with either Ms. Moss or Medicaid Eligibility until your call on May 8, 2007.

If you need any additional information, please feel free to contact me at 864-487-2717 ext. 510.

Sincerely,



Sandra L. Hoffner  
Business Office Manager

05/15/2007 09:35AM

05/15/2007 09:32 8544872798

PAGE 03/04



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MEDICAID PROGRAM

SECTION I - IDENTIFICATION OF PROVIDER AND PATIENT:  
NOTICE OF ADMISSION, AUTHORIZATION AND CHANGE OF STATUS FOR LONG TERM CARE

1. PATIENT'S NAME (FIRST, M, INITIAL, LAST)  <b>LINDA MOSS</b>	2. BIRTH DATE  <b>07-12-1941</b>	3. PATIENT'S MEDICAID I.D. NUMBER  <b>211 3266901</b>
4. PATIENT'S RESIDENT ADDRESS (SHEET NO. NAME, CITY, STATE & ZIP) <b>1434 N. Sumner St. Holly Springs, NC 27534</b>	5. COUNTY OF RESIDENCE <b>Cherokee</b>	6. SOCIAL SECURITY CLAIM NO. - HHS SUFFIX <b>1250-1681-0321-A</b>
7. PROVIDER'S NAME & ADDRESS (CITY & STATE) <b>Peaceville Dental 11 Peachtree Dunwoody 377597</b>	8. PROVIDER'S MEDICAID I.D. NO. <b>377597</b>	9. LAST DATE MEDICAID EXHAUSTED (MO, DAY, YR)
		10. DATE OF REQUEST (MO, DAY, YR)

SECTION II - TYPE OF COVERAGE AND STATISTICAL DATA - APPLICABLE TO COMPUTER BILLING FOR MONTH OF:

11. INITIAL COVERAGE AND/OR CHANGE IN STATUS (CHECK APPLICABLE BOX AND COMPLETE)
- (A) ☐ SKILLED CARE ☐ INTERMEDIATE CARE ☒ LONG TERM CONSUMPTION CARE ☐ PSYCHIATRIC CARE
- (B) CHANGE IN TYPE OF CARE: FROM \_\_\_\_\_ TO \_\_\_\_\_
- (C) MEDICAID ADMITTANCE DATE: \_\_\_\_\_ (MO) (DAY) (YR) \_\_\_\_\_ (MO) (DAY) (YR)
- (D) TRANSFERRED TO ANOTHER FACILITY: \_\_\_\_\_ (MO) (DAY) (YR) \_\_\_\_\_ (MO) (DAY) (YR)  
NAME OF OTHER FACILITY \_\_\_\_\_
- (E) TRANSFERRED FROM ANOTHER FACILITY: \_\_\_\_\_ (MO) (DAY) (YR) \_\_\_\_\_ (MO) (DAY) (YR)  
NAME OF OTHER FACILITY \_\_\_\_\_
- (F) TRANSFERRED TO HOSPITAL: \_\_\_\_\_ (MO) (DAY) (YR) \_\_\_\_\_ (MO) (DAY) (YR)  
NAME OF HOSPITAL \_\_\_\_\_
- (G) READMITTED FROM HOSPITAL STAY: \_\_\_\_\_ (MO) (DAY) (YR) \_\_\_\_\_ (MO) (DAY) (YR)  
NAME OF HOSPITAL \_\_\_\_\_
- (H) NUMBER OF DAYS ABSENT FROM FACILITY: \_\_\_\_\_ (MO) (DAY) (YR) \_\_\_\_\_ (MO) (DAY) (YR)  
COVERED DAYS \_\_\_\_\_ NON-COVERED DAYS \_\_\_\_\_
- (I) TERMINATION DATE: \_\_\_\_\_ (MO) (DAY) (YR) \_\_\_\_\_ (MO) (DAY) (YR)  
IF DECEASED, SPECIFY DATE OF DEATH: \_\_\_\_\_ (MO) (DAY) (YR) \_\_\_\_\_ (MO) (DAY) (YR)
- (J) DATE ADMITTED MEDICAID FOR THE CURRENT SPELL OF ILLNESS: \_\_\_\_\_ (MO) (DAY) (YR) \_\_\_\_\_ (MO) (DAY) (YR)
- (K) CONSUMPTION DATES THIS BILL: FROM: \_\_\_\_\_ (MO) (DAY) (YR) \_\_\_\_\_ (MO) (DAY) (YR) THROUGH: \_\_\_\_\_ (MO) (DAY) (YR) \_\_\_\_\_ (MO) (DAY) (YR) NO. OF DAYS \_\_\_\_\_

SPECIFY REASON FOR TERMINATION OR OTHER CHANGE IN STATUS IF NOT COVERED BY ABOVE ITEMS

SECTION III - AUTHORIZATION AND CHANGE OF STATUS:

12. RECOMMENDATION OF DHS MEDICAID ELIGIBILITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)

- (A) ☐ AUTHORIZATION TO BEGIN: \_\_\_\_\_ (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE \_\_\_\_\_
- DATE \_\_\_\_\_ (MO) (DAY) (YR) **Did not return needed information**
- (C) ☐ PATIENT'S INITIAL APPLICABLE REQUIRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) \$ \_\_\_\_\_
- (D) ☐ CHANGE IN PATIENT'S INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) EFFECTIVE: \_\_\_\_\_ \$ \_\_\_\_\_
- (E) ☐ NAME CHANGE: FROM \_\_\_\_\_ TO \_\_\_\_\_
- (F) ☐ OTHER (SPECIFY) \_\_\_\_\_

DHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY **Monte N. White** **2-8-07**  
DATE

DHS FORM 181 (JUL 02)

05/15/2007 09:35AM



05/15/2007 09:32 8644872798

PAGE 04/04



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MEDICAID HEALTH PROGRAM

NOTICE OF ADMISSION, AUTHORIZATION AND CHANGE OF STATUS FOR LONG TERM CARE  
SECTION I - IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (PRINT, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
LINDA MOSS	07-12-1941	2113266901
4. PATIENT'S RESIDENT ADDRESS (SHEET NO., NAME, CITY, STATE & ZIP) 134 N. KIMBERLY DR. PACIFIC, MO. 64650	5. COUNTY OF RESIDENCE Shannon	6. SOCIAL SECURITY CLAIM NO. - HHS SUFFIX 1250168103211A
7. PROVIDER'S NAME & ADDRESS (SHEET NO., NAME, CITY, STATE & ZIP) Leatrice Lee Lambie	8. PROVIDER'S MEDICAID I.D. NO. 377597	9. LAST DATE MEDICAID EXHAUST (MO, DAY, YR)
		10. DATE OF REQUEST (MO, DAY, YR)

SECTION II - TYPE OF COVERAGE AND STATISTICAL DATA -- APPLICABLE TO COMPUTER BILLING FOR MONTH OF:

11. INITIAL COVERAGE AND/OR CHANGE IN STATUS (CHECK APPLICABLE BOX AND COMPLETE)

- (A) ☐ SKILLED CARE ☐ INTERMEDIATE CARE ☐ SNF CONFINEMENT ☐ PSYCHIATRIC CARE
- (B) CHANGE IN TYPE OF CARE FROM \_\_\_\_\_ TO \_\_\_\_\_ (MO) (DAY) (YR)
- (C) MEDICAID ADMITTANCE DATE: \_\_\_\_\_ (MO) (DAY) (YR)
- (D) TRANSFERRED TO ANOTHER FACILITY \_\_\_\_\_ (MO) (DAY) (YR) NAME OF OTHER FACILITY \_\_\_\_\_
- (E) TRANSFERRED FROM ANOTHER FACILITY \_\_\_\_\_ (MO) (DAY) (YR) NAME OF OTHER FACILITY \_\_\_\_\_
- (F) TRANSFERRED TO HOSPITAL \_\_\_\_\_ (MO) (DAY) (YR) NAME OF HOSPITAL \_\_\_\_\_
- (G) READMITTED FROM HOSPITAL STAY \_\_\_\_\_ (MO) (DAY) (YR) NAME OF HOSPITAL \_\_\_\_\_
- (H) NUMBER OF DAYS ABSENT FROM FACILITY \_\_\_\_\_ (MO) (DAY) (YR) COVERED DAYS \_\_\_\_\_ NON-COVERED DAYS \_\_\_\_\_
- (I) TERMINATION DATE 12-29-06 IF DECREASED, SPECIFY DATE OF DEATH \_\_\_\_\_ (MO) (DAY) (YR)
- (J) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: \_\_\_\_\_ (MO) (DAY) (YR)

- (K) CONFINEMENT DATES THIS BILL FROM: \_\_\_\_\_ (MO) (DAY) (YR) THROUGH: \_\_\_\_\_ (MO) (DAY) (YR) NO. OF DAYS \_\_\_\_\_

SPECIFY REASON FOR TERMINATION OR OTHER CHANGE IN STATUS IF NOT COVERED BY ABOVE ITEMS

Discharged home on 12/29/06

SECTION III - AUTHORIZATION AND CHANGE OF STATUS:

12. RECOMMENDATION OF DHEHS MEDICAID ELIGIBILITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)

- (A) ☐ AUTHORIZATION TO BEGIN: (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE \_\_\_\_\_
- DATE \_\_\_\_\_ (MO) (DAY) (YR) Did not return needed information
- (C) ☐ PATIENT'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) \$ \_\_\_\_\_
- (D) ☐ CHANGE IN PATIENT'S INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) EFFECTIVE: \_\_\_\_\_ (MO) (YR) \$ \_\_\_\_\_
- (E) ☐ NAME CHANGE FROM \_\_\_\_\_ TO \_\_\_\_\_
- (F) ☐ OTHER (SPECIFY) \_\_\_\_\_

Notified N.ville 2-8-07

DHEHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY \_\_\_\_\_ DATE \_\_\_\_\_

DHEHS FORM 181 (JUL 02)

05/15/2007 09:35AM

AMDRSS02

SC DHHS - RECIPIENT INFORMATION

05/08/07

NAME: LINDA  
ADDR:

W MOSS

RECIP #: 2113266901 FAM #: 21132669  
SSCN (MCN/RRN): 250680321 A

131 E BELLS BRANCH RD  
BLACKSBURG

SSN: 250680321 PREFIX SSCN-MCN/RRN SUFFIX  
SC COUNTY: 11 LIV ARR: MED QUAL CAT: 50

ZIP: 29702

RSP IND: 0 TPL: N FACIL: ECF PAY CAT: 32

PAT NO: JBR0W

DSSDLU: 05/06/07

VA: N RACE: 01 BIRTH: 07/12/1941

HHSID: CLM20

HHSDLU: 04/18/07

SEX: 2 DEATH: 00/00/00

MEDICAID ELIG

INELIG PAY Q LS BUYIN-B ST

ELIG BUYIN-A ST ELIG

CURR: 07/01/02 00/00/00 32

CURR: 41

09/02 00/00 CURR: 0000 00/00 00/00

PRV1: 00/00/00 00/00/00

PRV1:

00/00 00/00 PRV1: 0000 00/00 00/00

PRV2: 00/00/00 00/00/00

PRV2:

00/00 00/00 PRV2: 0000 00/00 00/00

PRV3: 00/00/00 00/00/00

PRV3:

00/00 00/00 PRV3: 0000 00/00 00/00

PRV4: 00/00/00 00/00/00

PRV4:

00/00 00/00 PRV4: 0000 00/00 00/00

PRV5: 00/00/00 00/00/00

07/06

07/05 07/04

PRV6: 00/00/00 00/00/00

06/07

06/06 06/05

PRV7: 00/00/00 00/00/00

AM 2

0

PRV8: 00/00/00 00/00/00

HH 0

0

ESRD:

CP 0

0

ALT RECIP ID:

REV IND: 0

0

ALT RECIP ID:

MH

\*\* INFORMATION SUCCESSFULLY RETRIEVED \*\*

PF3->RSP SUMMARY

PF4->INQUIRY

PF5->FAMILY INFO

PF9->LIST SKEL CLAIMS

PF10->PREV MENU

PF11->LIST FAMILY MBRS

PF12->SKEL CLM INFO

PF14->MCR INFO

*864 487 2714 x 510 Sandra H.  
Leah true billed 5500.00*

*3 mos. Dos Oct, Nov, Dec. Jan*

*Melinda Willy - Medicaid Office  
864 487 2521*

*want  
talk to NH  
staff about  
residents -  
medical pendings  
cherokee city  
willye  
Dangle Dillinger*