DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

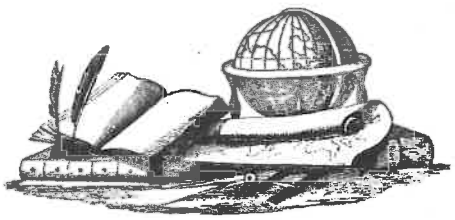
ACTION REFERRAL

TO	DATE
Singleton	4-24-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000677	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Cleared 5/1/07, letter attached. ✓	[X] Prepare reply for appropriate signature DATE DUE 5-3-07
	[ ] 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.			

Log - Singleton
"Approp. Sign"



Worldwide Resources, Incorporated
645 N. Michigan Avenue Suite 800
Chicago IL 60611
Phone: (312) 280-1375 FAX: (312) 751-0313
E-Mail: assureresearch@sbcglobal.net

4-19-07

Office of Public Information
Dept. of Health & Human Services
PO Box 8206
Columbia, SC 29202-8206

Attn: Correspondence Unit

Re: Carroll, Mary Ann
DOB: 12-13-50
ID# 7533166901
SS#: 249-35-9544

To Whom It May Concern:

Worldwide Resources is representing United of National Western Life Insurance with regard to a recent life insurance claim. In order to properly evaluate this claim, information from SC Medicaid is necessary. This is to request the following:

- Detailed claim history to include dates of service, provider names and addresses, amounts paid for all Medicaid claims in South Carolina or Georgia from 3-1-04 to 2-1-07.

Proper HIPAA authorizations, death certificate and "Affidavit of Legal Next of Kin" are attached. This is not a coordination of benefits or subrogation or third party liability matter. Should you have any questions pertaining to this request, please call (312) 802-6448. Please send all correspondence directly to the undersigned, as we need independent verification of claims, directly from the provider.

Thanking you in advance for your fine cooperation. Your timely response is most appreciated, as life benefits are pending.

Sincerely,

Sharon Jakush
Claims Consultant

HIPAA/ASCA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Insured/Patient Name: MARY ANN CARROLL Date of Birth: 12-13-50 SS# 249-35-9544

1. I, Nora Rackard, the Daughter of Mary Ann Carroll authorize all physicians, hospitals, dentists and/or pharmacies as well as their administrative and clinical staffs, HMOs and major medical or other insurance providers to include life and disability insurers and employers, medical examiners/coroners and other law enforcement officials to disclose the following protected health information to:

Worldwide Resources, Inc. 645 N. Michigan Ave. Suite 800. Chicago IL 60611 on behalf of National Western Life Insurance
regarding the above named Insured/Patient.

2. The protected health information to be included but not limited to is: diagnosis, care or treatment of psychiatric disorders, drug and alcohol abuse, treatment or prescriptions, testing and /or treatment of HIV (AIDS virus) and or other sexually transmitted diseases, treatments of all past or present illnesses. Specific records to be used or disclosured is:

Admission, History & Physical, Discharge Summary, Consultations, ER Records, Operative Reports, Physician Office Notes, Lab & XR, Claim Records, Pharmacy Records, Insurance Company Claim History, Medicaid Records

between the dates of: 2000 to Present.

3. This protected health information is being used or disclosed for the following purposes:

to evaluate the claim presented to :

National Western Life Insurance Company.

4. This authorization shall be in force and effective until the conclusion of the claim process or one year from the below date, which ever comes first, at which time this authorization to use or disclose this protected health information expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Worldwide Resources, Incorporated's Privacy Contact at 1325 W. Sunshine # 517 Springfield, MO 65807. I understand that a revocation is not effective to the extent that my physician, hospital, pharmacy or other health care provider, HMO or major medical insurer, or other life or disability insurer has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

7. I understand that I may refuse to sign this authorization. I realize that if I refuse to sign the claim process may be effected.

8. I further understand that I have a right to receive a copy of this authorization and agree that a copy of this authorization is to be accepted with the same authority as the original.

Nora R Carroll Rackard
Signature of Patient or Personal Representative

4-17-07
Date

Nora R Carroll Rackard
Print Name of Patient or Personal Representative

Daughter
Description of Personal Representative's Authority

Mar 19 2007 7:45AM WRI

CERTIFICATE OF DEATH/STATE OF GEORGIA

Birth Number | Local File Number | State File Number

TYPE OR PRINT IN PERMANENT BLACK OR BLUE-BLACK INK

DECEASED

1a. DECEDENT'S NAME (First, Middle, Last): Mary Ann Carroll
1b. IF DECEDENT IS FEMALE, ENTER MAIDEN LAST NAME: Riley
2. SEX: Female
3. DATE OF DEATH (Mo., Day, Year): January 23, 2007
4. RACE (White, Black, Amer. Indian, etc.) (Specify): White
5. ORIGIN OF DECEDENT (Italian, Mex., French, English, etc.): Irish
6. DATE OF BIRTH (Mo., Day, Year): Dec. 13, 1950
7a. AGE - Last Birthday (Years): 56
7b. UNDER 1 YEAR: Mos. / Days
7c. UNDER 1 DAY: Hours / Mins.
8a. COUNTY OF DEATH: Richmond
9a. CITY, TOWN or LOCATION OF DEATH: Augusta
9b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and No.): University Hospital
9c. IF HOSPITAL OR INST. (Indicate DOA, OP/EMER Rm., Inpatient) (Specify): Inpatient
10a. STATE AND COUNTY OF BIRTH (If not in USA, name Country): TN/Shelby
10b. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
12. SPOUSE (If married or widowed, give spouse's name - if wife, give maiden name): Peter Garard Carroll
13. WAS DECEDENT EVER IN U.S. ARMED FORCES (Yes or No): No
14. SOCIAL SECURITY NUMBER: 249-35-9544
15a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
15b. KIND OF INDUSTRY OR BUSINESS: Domestic

Usual Residence Where Deceased Lived. If Death Occurred in Institution, See Handbook Regarding Completion of Residence Items.

16a. RESIDENCE - STATE: SC
16b. COUNTY: Edgefield
16c. CITY, TOWN or LOCATION: North Augusta
16d. STREET AND NUMBER AND ZIP CODE: 306 Clay Court 29860
16e. INSIDE CITY LIMITS? (Yes or No): No

PARENTS

17. FATHER'S NAME First Middle Last: Tommy Riley
18. MOTHER'S MAIDEN NAME First Middle Last: Bonny Thresa Sherlock

INFORMANT

18a. INFORMANT'S NAME First Middle Last: Nora Ryckard
18b. MAILING ADDRESS (Street, R.F.D. No., City or Town, State, Zip): 209 Gardner Rd. North Augusta, SC 29860
18c. RELATIONSHIP: Daughter

DISPOSITION

19a. BURIAL, CREMATION, REMOVAL (Specify): Burial
19b. DISPOSITION DATE (Mo., Day, Year): Feb. 5, 2007
20a. CEMETERY OR CREMATORY NAME: Pineview Memorial Park
20b. LOCATION (City or Town, State, Zip, County): North Augusta, SC 29841 Aiken
21a. FUNERAL DIRECTOR (Signature): [signature]
21b. FUN. DIR. LICENSE NO.: 2397
21c. NAME AND ADDRESS OF FACILITY (Street, R.F.D. No., City or Town, State, Zip): Rowland Funeral Home, 637 W. Martintown Rd., North Augusta, SC 29841
21d. EMBALMER (Signature): [signature]
21e. EMBALMER LICENSE NO.: 1854
21f. EST. LICENSE NO.: 583

CAUSE OF DEATH

Conditions, If Any, Which Gave Rise To Immediate Cause Stating the Underlying Cause Last.

PART I
22. IMMEDIATE CAUSE: (Enter only one cause per line for A, B, and C)
a. CARDIORESPIRATORY ARREST — Approximate Interval between onset and death:
Due to, or as a consequence of:
b. CORONARY ARTERY DISEASE — Approximate Interval between onset and death:
Due to, or as a consequence of:
c. — Approximate Interval between onset and death:

PART II
23. OTHER SIGNIFICANT CONDITIONS - conditions contributing to death but not related to cause given in Part 1A. (If female, indicate if pregnant or birth occurred within 90 days of death.): COPD, HYPERTENSION, HYPERCHOLESTEROLEMIA
24. AUTOPSY (Yes or No): NO
25. IF YES, WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH? (Yes or No):
26a. WAS OPERATION PERFORMED (Yes or No): NO
26b. DATE OF OPERATION (Mo., Day, Year):
26c. CONDITIONS FOR WHICH OPERATION WAS PERFORMED (Specify):

If Infant Death, Indicate Birth Certificate No. of Mother.

27. ACCIDENT, SUICIDE, HOMICIDE, UNDETERMINED (Specify):
28a. DATE OF INJURY (Mo., Day, Year):
28b. DESCRIBE HOW INJURY OCCURRED:
28c. HOUR OF INJURY:
28d. INJURY AT WORK? (Yes or No):
28e. PLACE OF INJURY (Home, Farm, Street, Factory, Office, Etc.) (Specify):
28f. LOCATION (Street, R.F.D. No., City or Town, State, Zip, County):

CERTIFIER

To Be Completed By CERTIFYING PHYSICIAN ONLY

29a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title): [signature], MD
29b. DATE SIGNED (Mo., Day, Year): 2/2/07
29c. HOUR OF DEATH: 10:05 P M
29d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER:

To Be Completed By MEDICAL EXAMINER OR CORONER ONLY

30a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title):
30b. DATE SIGNED (Mo., Day, Year):
30c. HOUR OF DEATH:
30d. DATE PRONOUNCED DEAD (Mo., Day, Year):
30e. HOUR PRONOUNCED DEAD:

TYPE OR PRINT

31a. NAME, TITLE, AND LICENSE NO. OF CERTIFIER (Physician, Medical Examiner, or Coroner): GIRISA S. DAS, MD
PHYS. LIC. NO.: 035609
31b. ADDRESS OF CERTIFIER (Street, R.F.D. No., City or Town, State, Zip): 2123 Wrightsboro Rd Augusta, Ga 30904

REGISTRAR

22a. REGISTRAR (Signature): Kitty Don. Cofer, CR
22b. DATE RECEIVED BY REGISTRAR (Mo., Day, Year): February 5, 2007

3803 (Rev. 03/04) GEORGIA DEPARTMENT OF HUMAN RESOURCES/VITAL RECORDS SERVICE — DO NOT FOLD THIS CERTIFICATE

CERTIFICATE OF RECORD

THIS IS AN EXACT COPY OF THE DEATH CERTIFICATE RECEIVED FOR FILING IN RICHMOND COUNTY, GA.

[signature]
LOCAL CUSTODIAN

RECEIVED
MAR 07 2007
POLICY BENEFIT DEPT.

SIGNED BY: Kitty Don. Cofer

DATE: February 5, 2007

AFFIDAVIT OF LEGAL NEXT OF KIN

I Nora R. Carroll Rackard, being duly sworn, depose and say:

1. That I am the legal next of kin of Mary Ann Carroll, who died on or about the 23 day of Jan, 2007.

2. That no personal representative has been appointed for the decedent's estate in this state or elsewhere and no application for such an appointment is pending in this state or elsewhere.

3. That this affidavit is made in support of the undersigned's request for the release of record information.

Further, this affiant sayeth naught.

Dated the 17 day of April 2007.

Signature of Affiant: Nora R Carroll Rackard

Witness: _____

Notary Public:

The aforenamed Affiant Nora R. Carroll has been sworn and subscribed before me this 17 day of April, 2007.

MY COMMISSION EXPIRES JULY 6, 2010

Gloria E. Lewis
Signature of Notary Public

My commission expires on _____

Affix Notary Seal Here:

Log # 677

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

May 1, 2007

Ms. Sharon Jakush
Claims Consultant
Worldwide Resources, Incorporated
645 N. Michigan Avenue, Suite 800
Chicago, IL 60611

Re: Mary Ann Carroll

Dear Ms. Jakush:

Thank you for your courtesy in providing the HIPAA/ASCA Privacy Authorization Form. Enclosed is a Detailed Claims Report (DCR) for Ms. Mary Ann Carroll, as requested. The Department does not normally have clinical records; only information abstracted from provider claim forms. The DCR lists services billed to Medicaid as well as the amount Medicaid paid for services rendered between March 1, 2004 and February 1, 2007. This document is a true and accurate printout directly from computerized information kept in the normal course of Department business. Providers have one (1) year from the date of service to bill.

Our expense for reproducing this information is twenty-five and 55/100 dollars ($25.55), which includes the minimum charge of twenty-five dollars for computer time. Please make the check payable to the Department of Health and Human Services and send it to:

Department of Health and Human Services
Department of Receivables
Post Office Box 8297
Columbia, SC 29202

I hope this information is helpful to you. Please contact me if there are any questions.

Sincerely,

Richard G. Hepfer
Deputy General Counsel

RGH/h
Enclosures
cc: Lynette D. Wilson, Receivables (w/o enclosures)

Office of General Counsel
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2795 Fax (803) 255-8210