DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton	1-4-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000439	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Mr. Kerr Cleared 1/19/07 (see attached e-mail.	[X] Prepare reply for appropriate signature DATE DUE 1-16-07 [ ] 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.			

Columbia
Urban League

1400 Barnwell Street
Columbia, SC 29201

P 803 799 8150
F 803 254 6052

www.columbiaurbanleague.org

Log - Deirdra
Approp. Sign. "
cc: Robby

Empowering Communities.
Changing Lives.

December 27, 2006

Mr. Robby Kerr
Director
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, SC 29202-8206

Dear Robby,

Re: Silver Plan

Attached is the information from Ms. Drucetta Goodson that we discussed on Friday, December 22, 2006. Ms. Goodson called me concerning the Silver Plan. She believes that she may have been deceived by Peter Nepita, the representative from Silver Care of South Carolina, a representative of Medicare Advantage Plans, Life Insurance. Also, she is concerned about whether or not her Medicaid plan has been compromised.

Thank you for your review of this matter.

Sincerely,

James T. McLawhorn, Jr.
President and Chief Executive Officer

JTMjr/ch

Mailing Address:
PO Box 100298
Columbia, SC 29202-3298
1-877-446-7845

Please complete all pages

InStil Health

ENROLLMENT APPLICATION

Medicare Advantage Private Fee-for-Service

RECEIVED
DEC 27 2006
Department of Health & Human Services
OFFICE OF THE DIRECTOR

InStil Health

Medicare Advantage Private Fee-for-Service ENROLLMENT APPLICATION

Requested Effective Date: [illegible] Agent Name: Pete Nepite Agent ID #: [illegible]

Choose the InCare Plan in which you would like to enroll:

☒ Midland/Central	SC Premium per month $0	☐ North Central	GA	Premium per month $7
☐ Pee Dee	SC Premium per month $61	☒ Western	GA	Premium per month $0
☐ Low Country	SC Premium per month $27	☐ Coastal	GA	Premium per month $22
		☐ Southeast	GA	Premium per month $48

LAST Name:	FIRST Name:	MIDDLE Initial:	☐ Mr. ☒ Mrs. ☐ Ms.
GOODSON	DIANNA	P	

Birth Date: (M M - D D - Y Y Y Y)	Sex:	Social Security Number: (providing this information is optional)	Home Phone Number:
(7 [illegible] 1924)	☐ M ☒ F	062-[illegible]	803 [illegible]

Permanent Residence Street Address: 60 LAFAYETTE ST.

City:	State:	ZIP Code:	County:
Columbia	SC	29203	Richland

Mailing Address (only if different from your Permanent Residence Address):

Street Address:

City:	State:	ZIP Code:

Emergency contact: ~~Otto~~ Thelma Brand (803) [illegible] Phone Number Relationship: Nephew

E-mail Address: (Optional)

Please take out your Medicare Card to complete this section.

- Please fill in the blanks as shown on your red, white and blue Medicare card.

— OR —

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

Name of Medicare Member: DIANNA P GOODSON

Medicare Claim Number: 249-24-7375 D

Sex: F

Effective Date:

HOSPITAL (Part A): 1-1-1926

MEDICAL (Part B): 3-1-1926

YOUR PLAN PREMIUM OPTIONS

You can have the monthly premium for this Medicare Advantage plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by Electronic Funds Transfer (EFT). Generally you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare Advantage coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

Would you like the premium for this plan deducted from your SSA monthly benefit check? ☒ Yes ☐ No
Generally, two months of premiums will be withheld from the first payment and after that a single monthly premium will be withheld each month.

Please Answer the Following Questions to Help Us Process Your Enrollment

1. Are you aging into Medicare? ☐ Yes ☒ No
   Are you moving into an InStil Health area? ☐ Yes ☒ No
   Are you leaving an employer plan? ☐ Yes ☒ No

2. Do you have a Medigap or Medicare supplement? ☐ Yes ☒ No

3. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☒ No
   If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

4. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☒ No
   If "yes," please provide the following information:
   Name of Facility: _____
   Address and Phone Number of Facility (number and street): _____

5. Are you enrolled in your State Medicaid program? ☒ Yes ☐ No
   If "yes", please provide your Medicaid number and attach a copy of your Medicaid papers. 996177101

6. Do you or your spouse work? ☐ Yes ☒ No

Please check below if you would prefer us to send you information in a language other than English:
☐ Spanish

STOP

If you have health coverage from an employer or union, joining InStil Health could affect your health benefits. If you have health coverage from an employer or union, joining InStil Health could affect your health benefits. If you have health coverage from an employer or union, joining InStil Health could affect your health benefits. Read the communications your employer or union sends about your coverage or visit their Web site or contact the office listed in their communications. If you have questions about how to continue your benefits, contact your benefits administrator or the office that answers questions

Silver Care
of
South Carolina

Peter Nepita
Representative
Medicare Advantage Plans, Life Insurance
803-361-4319 (Cell)
803-783-8822 (FAX)

1-877-486-2048

Columbia
Urban League | 1400 Barnwell Street
Columbia, SC 29201

Hand Delivered

Mr. Robby Kerr
SC Department of Health and Human Services
1801 Main Street
Columbia, SC 29202-8206

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton	1-4-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
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	[ ] 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. DMS	1/19/07		See attached email
2.			
3.			
4.			

From: Kathleen Snider
To: Deirdra Singleton
Date: 1/19/2007 3:49:06 PM
Subject: Disposition of Complaint Forwarded by Columbia Urban League

Mr. James T. McLawhorn, President of the Columbia Urban League, requested DHHS to review a complaint by one of his clients regarding a Medicare Advantage Plan, via correspondence sent to DHHS on December 22nd and forwarded to the Office of General Counsel on 1/4/07 as Log # 000439. The following actions were taken to resolve this issue:

1. I contacted Mr. McLawhorn's client by telephone on 01/11/07 to gain a better understanding of the nature of her concern. She had been approached by an agent of InStill Health who had convinced her to sign an enrollment application for a Medicare Advantage Plan. She was satisfied with her current coverage from Medicare and Medicaid and wanted to drop any additional coverage she may have signed up for. She also felt she was deceived by the Medicare Advantage Plan agent, and did not want her Medicaid benefits compromised.
2. Since this was not directly a Medicaid issue, on 1/12/07 I contacted the SC Department of Insurance, Consumer Complaint Division, and discussed the situation of the analyst there. She researched the insurance company and gave me a number for the client to call in order to drop the InStill Health coverage.
3. On 1/12/07, I gave this information to you, and you were able to subsequently contact Mr. McLawhorn and give this information to him to give to his client.
4. On 1/16/07, I again contacted Mr.McLawhorn's client, and she said that she had already contacted InStill Health and requested that her enrollment application be voided.

The concerns of Mr.McLawhorn and his client have been satisfactorily addressed.

Kathleen C. Snider, Bureau Chief
Compliance and Performance Review
SC Department of Health and Human Services
1801 Main Street, Columbia SC 29202-8206
(803) 898-1050

Columbia
Urban League

1400 Barnwell Street
Columbia, SC 29201

P 803 799 8150
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www.columbiaurbanleague.org

Empowering Communities.
Changing Lives.

Log - Deirdra
Approp. Sign. "
cc: Robby

December 27, 2006

Mr. Robby Kerr
Director
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, SC 29202-8206

Dear Robby,

Re: Silver Plan

Attached is the information from Ms. Drucetta Goodson that we discussed on Friday, December 22, 2006. Ms. Goodson called me concerning the Silver Plan. She believes that she may have been deceived by Peter Nepita, the representative from Silver Care of South Carolina, a representative of Medicare Advantage Plans, Life Insurance. Also, she is concerned about whether or not her Medicaid plan has been compromised.

Thank you for your review of this matter.

Sincerely,

James T. McLawhorn, Jr.
President and Chief Executive Officer

JTMjr/ch

Mailing Address:
PO Box 100298
Columbia, SC 29202-3298
[illegible]-7845

Please complete all pages

InStil Health

ENROLLMENT APPLICATION

Medicare Advantage Private Fee-for-Service

InStil Health

Medicare Advantage Private Fee-for-Service ENROLLMENT APPLICATION

Requested Effective Date: Jan 1 07 Agent Name: Peter Nepute Agent ID #: 124025

Choose the InCare Plan in which you would like to enroll:

- ☒ Midlands/Central SC Premium per month $0
- ☐ Pee Dee SC Premium per month $61
- ☐ Low Country SC Premium per month $27
- ☐ North Central GA Premium per month $7
- ☐ Western GA Premium per month $0
- ☐ Coastal GA Premium per month $22
- ☐ Southeast GA Premium per month $48

LAST Name:	FIRST Name:	MIDDLE Initial	
GOODSON	DRUETTA	P	☐ Mr. ☒ Mrs. ☐ Ms.

Birth Date: (MM-DD-YYYY)	Sex:	Social Security Number: (providing this information is optional)	Home Phone Number:
(7-15-1924)	☐ M ☒ F	062-38-[illegible]	(803) 806-3642

Permanent Residence Street Address: 2500 CARVER ST.

City:	State:	ZIP Code:	County:
Columbia	SC	29203	Richland

Mailing Address (only if different from your Permanent Residence Address):
Street Address:

City:	State:	ZIP Code:

Emergency contact: ~~Otto~~ Thelma Phone Number: (803) [illegible] Relationship: Brother

E-mail Address: (Optional)

Please take out your Medicare Card to complete this section.

- Please fill in these blanks as they appear on your red, white and blue Medicare card.

— OR —

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

Name of Medicare Member: DRUETTA P GOODSON

Medicare Claim Number: 249-24-7375 D Sex: F

Effective Date:

HOSPITAL (Part A)	1/1/1986
MEDICAL (Part B)	1/1/1986

YOUR PLAN PREMIUM OPTIONS

You can have the monthly premium for this Medicare Advantage plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by Electronic Funds Transfer (EFT). Generally you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare Advantage coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

Would you like the premium for this plan deducted from your SSA monthly benefit check? ☒ Yes ☐ No
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[illegible]

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   Are you leaving an employer plan? ☐ Yes ☒ No

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3. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☒ No
   If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

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   Address and Phone Number of Facility (number and street): _____

5. Are you enrolled in your State Medicaid program? ☒ Yes ☐ No
   If "yes", please provide your Medicaid number and attach a copy of your Medicaid papers. 996177101

6. Do you or your spouse work? ☐ Yes ☒ No

Please check below if you would prefer us to send you information in a language other than English:
☐ Spanish

STOP

[illegible] health coverage from an employer or union, joining InStil Health could affect [illegible] health benefits. If you have health coverage from an employer or union, joining [illegible] coverage works. Read the communications your employer or union [illegible] on their Web site or contact the office listed in their communications. If [illegible] contact your benefits administrator or the office that answers questions

Silver Care
of
South Carolina

Peter Nepita
Representative
Medicare Advantage Plans, Life Insurance
803-361-4319 (Cell)
803-783-8822 (FAX)

1-877-486-2048