

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

ACTION REFERRAL

TO <i>Myers</i>	DATE <i>3-24-09</i>
------------------------	----------------------------

DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER <i>100522</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>4-2-09</i>	<input type="checkbox"/> FOIA DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Ms. Forlmer</i> <i>Cleared 3/31/09, letter</i> <i>attached.</i>	<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.			



Evenings | Weekends | Family Care | Urgent Care

3/23/09

Emma Forkner
Department of Health and Human Services
P.O.Box 8206
Columbia, SC 29202

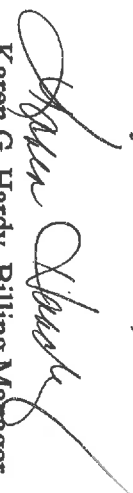
Dear Ms. Forkner;

I am sending this to you, as I cannot get this issue resolved. This would be my 9th request to have someone handle this problem. We continue to get ECF's for Dr. Shreedhar M. Nagnur. He is no longer affiliated with Doctors Care and someone needs to correct your records. We are not receiving checks for this physician, so your records must already be corrected somewhere in your system.

Please get someone to handle this issue as quickly as possible

You can reach me at 803-782-6561 ext 243 or via email at Karen.hardy@doctorscare.com.

Thank you in advance,


Karen G. Hardy, Billing Manager
Doctors Care
4416 Forest Drive
Columbia, SC 29206

Corporate Office

4416 Forest Drive, 2nd Floor

Columbia, SC 29206

ph 803-782-4278

web www.DoctorsCare.com

*Logi Myers
Appro Sign.
CC: Ms. Forkner*

RECEIVED
MAR 24 2009
Department of Health & Human Services
OFFICE OF THE DIRECTOR

DSC

PROVIDER ID. 000131146
 DEPT OF HEALTH AND HUMAN SERVICES
 1538168968
 SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
 REMITTANCE ADVICE

PAYMENT DATE
 03/13/2009

PAGE
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PROVIDER'S OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME	M O D	TLE. 18 ALLOWED D CHARGES	COPAY AMT	TITLE 18 PAYMENT
A1467T193	0905602307004700A 01		100407	99308	90.00 90.00	0.00 0.00	R 3061087301	R L DONALDSON EDITS: L00 316 EDITS: L01 953	000	L01 510	0.00	0.00
A1467T135	0905602308004700A 01		091807	99306	175.00 175.00	0.00 0.00	R 3061087301	R L DONALDSON EDITS: L00 316 EDITS: L01 953	000	L01 510	0.00	0.00
A1467T333	0905602309004700A 01		101607	99308	90.00 90.00	0.00 0.00	R 3061087301	R L DONALDSON EDITS: L00 316 EDITS: L01 953	000	L01 510	0.00	0.00
A1467T384	0905602310004700A 01 02		010108 012908	99308 99308	180.00 90.00 90.00	0.00 0.00 0.00	R 3061087301	R L DONALDSON EDITS: L00 316 EDITS: L01 953 EDITS: L02 953	000 000	L01 510 L02 510	0.00 0.00	0.00 0.00
A1467T133	0905602311004700A 01		032708	99308	90.00 90.00	0.00 0.00	R 1023148501	K S CAGLE EDITS: L00 316	000	L01 953	0.00	0.00
A1467T525	0905602312004700A 01		011508	99308	90.00 90.00	0.00 0.00	R 8718046501	B J HORNER EDITS: L00 316 EDITS: L01 953	0GV	L01 510	0.00	0.00
A1467T612	0905602313004700A 01		012908	99309	130.00 130.00	0.00 0.00	R 1327080201	H CHAVIS EDITS: L00 316 EDITS: L01 953	000	L01 510	0.00	0.00

\$0.00

FOR AN EXPLANATION OF THE
 ERROR CODES LISTED ON THIS
 FORM REFER TO: "MEDICAID
 PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS
 PHONE THE D.H.H.S. NUMBER
 SPECIFIED FOR INQUIRY OF
 CLAIMS IN THAT MANUAL.

CERT. PG TOT	MEDICAID PG TOT
CERTIFIED AMT	MEDICAID TOTAL
	CHECK TOTAL

STATUS CODES:
 P = PAYMENT MADE
 R = REJECTED
 S = IN PROCESS
 E = ENCOUNTER
 CHECK NUMBER

PROVIDER NAME AND ADDRESS
 SHREEDHAR M NAGNUR
 DOCTOR'S CARE PA
 PO BOX 100193
 COLUMBIA SC 29202

PROVIDER ID. 000131147
 DEPT OF HEALTH AND HUMAN SERVICES
 1538168968
 SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
 REMITTANCE ADVICE

PAYMENT DATE
 03/13/2009

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PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
A1467T808	0905602314004700A 01		112007	99309	130.00 130.00	0.00 R 0.00 R	1327080201	H CHAVIS EDITS: L00 316 EDITS: L01 953	000	L01 510	0.00	0.00
A1467T989	0905602315004700A 01		121107	99308	90.00 90.00	0.00 R 0.00 R	1327080201	H CHAVIS EDITS: L00 316 EDITS: L01 953	000	L01 510	0.00	0.00
A1467T120	0905602316004700A 01		030708	99308	90.00 90.00	0.00 R 0.00 R	1327080201	H CHAVIS EDITS: L00 316	000	L01 953	0.00	0.00
A1467T119	0905602317004700A 01		091107	99308	90.00 90.00	0.00 R 0.00 R	1023148501	K S CAGLE EDITS: L00 316 EDITS: L01 953	000	L01 510	0.00	0.00
A1467T169	0905602318004700A 01		100407	99309	130.00 130.00	0.00 R 0.00 R	1023148501	K S CAGLE EDITS: L00 316 EDITS: L01 953	000	L01 510	0.00	0.00
A1467T210	0905602319004700A 01		100907	99307	39.00 39.00	0.00 R 0.00 R	1023148501	K S CAGLE EDITS: L00 316 EDITS: L01 953	000	L01 510	0.00	0.00
A1467T407	0905602320004700A 01		103007	99308	90.00 90.00	0.00 R 0.00 R	1023148501	K S CAGLE EDITS: L00 316 EDITS: L01 953	000	L01 510	0.00	0.00
A1467T505	0905602321004700A 01		010808	99309	130.00 130.00	0.00 R 0.00 R	1023148501	K S CAGLE EDITS: L00 316	000	L01 510	0.00	0.00

\$0.00

FOR AN EXPLANATION OF THE
 ERROR CODES LISTED ON THIS
 FORM REFER TO: "MEDICAID
 PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS
 PHONE THE D.H.H.S. NUMBER
 SPECIFIED FOR INQUIRY OF
 CLAIMS IN THAT MANUAL.

CERT. PG TOT

CERTIFIED AMT

MEDICAID PG TOT

MEDICAID TOTAL

CHECK TOTAL

STATUS CODES:

P = PAYMENT MADE
 R = REJECTED
 S = IN PROCESS
 E = ENCOUNTER

CHECK NUMBER

PROVIDER NAME AND ADDRESS

SHREEDHAR M MAGNUR
 DOCTOR'S CARE PA
 PO BOX 100193
 COLUMBIA SC 29202

PROVIDER ID. 000131148
 DEPT OF HEALTH AND HUMAN SERVICES
 1538168968
 SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
 REMITTANCE ADVICE

PAYMENT DATE
 03/13/2009

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PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT T MEDICAID S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
A1467T539	0905602322004700A 01		090407	99306	175.00 175.00	0.00 0.00	R 1023148501	K S CAGLE EDITS: L01 953				
A1467T577	0905602323004700A 01		012208	99307	39.00 39.00	0.00 0.00	R 1023148501	K S CAGLE EDITS: L00 316 EDITS: L01 953		L01 510	0.00	0.00
A1467T972	0905602324004700A 01		120407	99308	90.00 90.00	0.00 0.00	R 1023148501	K S CAGLE EDITS: L00 316 EDITS: L01 953		L01 510	0.00	0.00
A1467T109	0905602325004700A 01		021408	99308	90.00 90.00	0.00 0.00	R 1023148501	K S CAGLE EDITS: L00 316 EDITS: L01 953		L01 510	0.00	0.00
A1467T109	0905602326004700A 01		021408	99308	90.00 90.00	0.00 0.00	R 8718046501	B J HORNER EDITS: L00 316 EDITS: L01 953		L01 510	0.00	0.00
A1467T976	0905602327004700A 01		120407	99309	130.00 130.00	0.00 0.00	R 8718046501	B J HORNER EDITS: L00 316 EDITS: L01 953		L01 510	0.00	0.00
A1467T405	0905602328004700A 01		103007	99309	130.00 130.00	0.00 0.00	R 8718046501	B J HORNER EDITS: L00 316 EDITS: L01 953		L01 510	0.00	0.00

\$0.00

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CERT. PG TOT

MEDICAID PG TOT

CERTIFIED AMT

MEDICAID TOTAL

CHECK TOTAL

STATUS CODES:

P = PAYMENT MADE
 R = REJECTED
 S = IN PROCESS
 E = ENCOUNTER

CHECK NUMBER

PROVIDER NAME AND ADDRESS

SHREEDHAR M NAGNUR
 DOCTOR'S CARE PA
 PO BOX 100193
 COLUMBIA SC 29202

PROVIDER ID. 000131149
 DEPT OF HEALTH AND HUMAN SERVICES
 1538168968
 SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
 REMITTANCE ADVICE

PAYMENT DATE
 03/13/2009

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PROVIDER'S OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE DATE(S) MMDDYY	RENDERED PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
A1467T248	0905602329004700A 01		100907	99308	90.00 90.00	0.00 0.00	R 6727505601	EDITS: L00 316 EDITS: L01 510	OGV	L00 950	0.00	0.00
A1467T290	0905602330004700A 01		101607	99307	39.00 39.00	0.00 0.00	R 6727805601	JOLLEY EDITS: L00 316 EDITS: L01 953	OGV	L01 510	0.00	0.00
A1467T106	0905602331004700A 01		091107	99306	175.00 175.00	0.00 0.00	R 6727805601	JOLLEY EDITS: L00 316 EDITS: L01 953	OGV	L01 510	0.00	0.00
A1467T117	0905602332004700A 01		030108	99308	90.00 90.00	0.00 0.00	R 6727805601	JOLLEY EDITS: L00 316	OGV	L01 953	0.00	0.00
A1467T101	0905602333004700A 01		121707	99308	90.00 90.00	0.00 0.00	R 6727805601	JOLLEY EDITS: L00 316 EDITS: L01 953	OGV	L01 510	0.00	0.00
A1467T204	0905602334004700A 01		091307	99308	90.00 90.00	0.00 0.00	R 3780103693	N J DARBY EDITS: L00 316 EDITS: L01 953	OGV	L01 510	0.00	0.00
A1467T129	0905602335004700A 01		091807	99306	175.00 175.00	0.00 0.00	R 1327080201	H CHAVIS EDITS: L00 316 EDITS: L01 953	OGV	L01 510	0.00	0.00
A1467T435	0905602336004700A 01		010108	99308	90.00 90.00	0.00 0.00	R 7716446701	M WALKER EDITS: L01 510	000		0.00	0.00

\$0.00

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CERT. PG TOT

CERTIFIED AMT

MEDICAID PG TOT

MEDICAID TOTAL

CHECK TOTAL

STATUS CODES:

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CHECK NUMBER

PROVIDER NAME AND ADDRESS

SHREEDHAR M NAGNUR
 DOCTOR'S CARE PA
 PO BOX 100193
 COLUMBIA SC 29202

PROVIDER ID. 000131150
 DEPT OF HEALTH AND HUMAN SERVICES
 1538168968
 SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
 REMITTANCE ADVICE

PAYMENT DATE
 03/13/2009

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PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
A1467T107	0905602337004700A 01		020708	99308	90.00 90.00	0.00 0.00	R 7716446701	M WALKER EDITS: L01 510	000		0.00	0.00
A1467T118	0905602338004700A 01		030708	99308	90.00 90.00	42.95 42.95	P 7716446701	M WALKER	000		0.00	0.00
A1467T120	0905607110017400A 01		030708	99308	90.00 90.00	0.00 0.00	S 3061087301	R L DONALDSON	000		0.00	0.00
A1467T152	0905607111017400A 01		092507	99306	175.00 175.00	0.00 0.00	S 2388688001	M WYATT	0GV		0.00	0.00
A1467T24	0905607112017400A 01		011707	99308	90.00 90.00	0.00 0.00	S 3780103693	N J DARBY	000		0.00	0.00
A1467T309	0905607113017400A 01		041907	99308	90.00 90.00	0.00 0.00	S 3780103693	N J DARBY	000		0.00	0.00
A1467T583	0905607114017400A 01		012208	99308	90.00 90.00	0.00 0.00	S 6727805601	R JOLLEY	0GV		0.00	0.00
A1467T824	0905607115017400A 01		112207	99309	130.00 130.00	0.00 0.00	S 3061087301	R L DONALDSON	000		0.00	0.00
A1467T134	0905607116017400A 01		041708	99308	90.00 90.00	0.00 0.00	S 3061087301	R L DONALDSON	000		0.00	0.00
A1467T123	0905607117017400A 01		040208	99308	90.00 90.00	0.00 0.00	S 1023148501	K S CAGLE	000		0.00	0.00
A1467T84	0905607118017400A 01		090407	99306	175.00 175.00	0.00 0.00	S 8718046501	B J HORNER	000		0.00	0.00
A1467T128	0905607119017400A 01		041408	99308	90.00 90.00	0.00 0.00	S 1327080201	H CHAVIS	000		0.00	0.00

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 CLAIMS IN THAT MANUAL.

CERT. PG TOT	\$42.95
CERTIFIED AMT	MEDICAID PG TOT
	MEDICAID TOTAL
	CHECK TOTAL

STATUS CODES:
 P = PAYMENT MADE
 R = REJECTED
 S = IN PROCESS
 E = ENCOUNTER
 CHECK NUMBER

PROVIDER NAME AND ADDRESS
 SHREEDHAR M NAGNUR
 DOCTOR'S CARE PA
 PO BOX 100193
 COLUMBIA SC 29202

PROVIDER ID.
1538168968

000131151
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE
03/13/2009

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PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
A1467T113	0905607120017400A 01		022808	99307	39.00 39.00	0.00 0.00	S 1023148501	K S CAGLE	000		0.00	0.00
A1467T160	0905607121017400A 01		100407	99308	90.00 90.00	0.00 0.00	S 8718046501	B J HORNER	0GV		0.00	0.00
A1467T320	0905607122017400A 01		101607	99308	90.00 90.00	0.00 0.00	S 1327080201	H CHAVIS	0GV		0.00	0.00
A1467T500	0905607123017400A 01		082107	99308	90.00 90.00	0.00 0.00	S 3780103693	N J DARBY	0GV		0.00	0.00
A1467T709	0905607124017400A 01		110607	99309	130.00 130.00	0.00 0.00	S 6727805601	R JOLLEY	0GV		0.00	0.00
A1467T144	0905607125017400A 01		051208	99307	39.00 39.00	0.00 0.00	S 1023148501	K S CAGLE	000		0.00	0.00
TOTALS			48		4985.00	42.95					0.00	0.00

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FORM REFER TO: "MEDICAID
PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS
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SPECIFIED FOR INQUIRY OF
CLAIMS IN THAT MANUAL.

CERT. PG TOT	\$0.00
CERTIFIED AMT	
MEDICAID PG TOT	
MEDICAID TOTAL	
CHECK TOTAL	

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER
CHECK NUMBER

PROVIDER NAME AND ADDRESS
SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA SC 29202

000131152
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PAGE

03/13/2009

7

TOTALS

00000

0.00

0.00

DEBIT BALANCE
PRIOR TO THIS
REMITTANCE

75.70

**YOUR CURRENT
DEBIT BALANCE**

32.75

MEDICAID TOTAL

42.95

ADJUSTMENTS

-75.70

CHECK TOTAL

0.00

CERTIFIED AMT

0.00]

0.001

CHECK NUMBER

PROVIDER NAME AND ADDRESS

SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

**TO BE REFUNDED
IN THE FUTURE**

0.001

SC 29202

RUN DATE 03/10/2009 000131153
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM

CLAIM CONTROL #0905602307004700A
PAGE 36143 ECF 36143 PAGE 1 OF 1

ANALYST ID
SIGNON ID

HIC - 20 PRAC SPEC - 15
DOC IND N

EMC
ORIGINAL CCN:
ADJ CCN:

TAXONOMY:
1 2
PROV/XWALK RECIPIENT
ID ID
221904 3061087301
NPI: 1538168968

SFL ZIP: 29817
3 4 5
P AUTH TPL INJURY
NUMBER CODE
H

PRV ZIP: 30023
6 7
EMERG PC COORD

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
707.03

EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - ROBERT L DONALDSON

11 DATE OF BIRTH 01/14/1963 12 SEX M

LINE EDITS
01) 510

13 14 15 16 17 18
RES ALLOWED LN DATE OF PLACE PROC
NO SERVICE CODE

19 20 21 22
INDIVIDUAL CHARGE PAY UNITS
PROV/XWALK IND

23
NDC

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 10/04/07 32 99308 000 221904 90.00 1.000
NPI: 1538168968 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID

27 TOTAL CHARGE 90.00

01 248335519A

28 AMT REC'D INS

02

29 BALANCE DUE 54.05

03

30 OWN REF # A1467T193

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131154
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM

CLAIM CONTROL #0905602308004700A
PAGE 36144 ECF 36144 PAGE 1 OF 1

ANALYST ID
SIGNON ID

HIC - 20 PRAC SPEC - 15
DOC IND N

EMC
ORIGINAL CCN:
ADJ CCN:

TAXONOMY:
1
PROV/XWALK RECIPIENT
ID ID
221904 3061087301
NPI: 1538168968

SFL ZIP: 29817
3
P AUTH TPL INJURY
NUMBER CODE
H

PRV ZIP: 30023
6
EMERG PC COORD
7
8
DIAGNOSIS
PRIMARY SECONDARY
780.39 401.1

EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - ROBERT L DONALDSON

11 DATE OF BIRTH 01/14/1963 12 SEX M

LINE EDITS
01) 510

13 RES 14 ALLOWED LN 15 DATE OF SERVICE 16 PLACE 17 PROC CODE 18 MOD 19 INDIVIDUAL PROV/XWALK 20 CHARGE IND 21 PAY 22 UNITS

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 09/18/07 31 99306 000 221904 175.00 1.000
NPI: 1538168968 TAXONOMY:

2 / /
NPI: TAXONOMY:

3 / /
NPI: TAXONOMY:

4 / /
NPI: TAXONOMY:

5 / /
NPI: TAXONOMY:

6 / /
NPI: TAXONOMY:

7 / /
NPI: TAXONOMY:

8 / /
NPI: TAXONOMY:

24 INS CARR NUMBER 25 POLICY NUMBER 26 INS CARR PAID

27 TOTAL CHARGE 175.00

01 248335519A

28 AMT REC'D INS

02

29 BALANCE DUE 106.85

03

30 OWN REF # A1467T135

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131155
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15

CLAIM CONTROL #0905602309004700A
PAGE 36145 ECF 36145 PAGE 1 OF 1

ANALYST ID
SIGNON ID

TAXONOMY:
1 2
PROV/XWALK RECIPIENT
ID ID
221904 3061087301
NPI: 1538168968

SFL ZIP: 29817
3 4 5
P AUTH TPL INJURY
NUMBER CODE
H

PRV ZIP: 30023
6 7
EMERG PC COORD

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
707.00 344.1

EMC
ORIGINAL CCN:
ADJ CCN:

EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - ROBERT L DONALDSON

11 DATE OF BIRTH 01/14/1963 12 SEX M

13 RES 14 ALLOWED LN 15 DATE OF SERVICE 16 PLACE 17 PROC CODE

18 MOD

19 INDIVIDUAL CHARGE 20 PAY 21 UNITS
PROV/XWALK IND

23
NDC

LINE EDITS
01) 510

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 10/16/07 32 99308 000 221904 90.00 1.000
NPI: 1538168968 TAXONOMY:

2 / /
NPI: TAXONOMY:

3 / /
NPI: TAXONOMY:

4 / /
NPI: TAXONOMY:

5 / /
NPI: TAXONOMY:

6 / /
NPI: TAXONOMY:

7 / /
NPI: TAXONOMY:

8 / /
NPI: TAXONOMY:

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID

27 TOTAL CHARGE 90.00

01 248335519A

28 AMT REC'D INS

02

29 BALANCE DUE 54.05

03

30 OWN REF # A1467T333

RESOLUTION DECISION ____

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131156
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15
DOC IND N

CLAIM CONTROL #0905602310004700A
PAGE 36146 ECF 36146 PAGE 1 OF 1

ANALYST ID
SIGNON ID

TAXONOMY:

1 2
PROV/XWALK RECIPIENT
ID ID
221904 3061087301
NPI: 1538168968

SFL ZIP: 29817

PRV ZIP: 30023

3 4 5
P AUTH TPL INJURY
NUMBER CODE
H

6 7
EMERG PC COORD

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
401.1 599.0

EMC
ORIGINAL CCN:
ADJ CCN:

EDITS
INSURANCE EDITS
01-953 02-953

CLAIM EDITS
316

10 RECIPIENT NAME - ROBERT L DONALDSON

11 DATE OF BIRTH 01/14/1963 12 SEX M

13 14 15 16 17 18 19 20 21 22
RES ALLOWED LN DATE OF PLACE PROC MOD INDIVIDUAL CHARGE PAY UNITS
NO SERVICE CODE PROV/XWALK IND

23
NDC

LINE EDITS
01) 510
02) 510

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID

01 248335519A

02

03

27 TOTAL CHARGE 180.00

28 AMT REC'D INS

29 BALANCE DUE 91.64

30 OWN REF # A1467T384

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131157

REPORT NUMBER CLM3500

ANALYST ID

SIGNON ID

TAXONOMY:

1 2
PROV/XWALK RECIPIENT
ID ID
221904 1023148501
NPI: 1538168968

SFL ZIP: 29817

PRV ZIP: 30023

3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE
H

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
453.8 564.00

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 20 PRAG SPEC - 15

DOC IND N

CLAIM CONTROL #0905602311004700A

PAGE 36147 ECF 36147 PAGE 1 OF 1

EMC

ORIGINAL CCN:

ADJ CCN:

EDITS

INSURANCE EDITS

01-953

CLAIM EDITS

316

10 RECIPIENT NAME - KIMBERLY S CAGLE

11 DATE OF BIRTH 10/25/1957

12 SEX F

LINE EDITS

13 RES	14 ALLOWED	15 LN NO	16 DATE OF SERVICE	17 PLACE	18 PROC CODE	19 MOD	20 INDIVIDUAL PROV/XWALK	21 CHARGE IND	22 PAY UNITS
	.00	1	03/27/08	32	99308	000	221904	90.00	1.000
	NPI: 1538168968	2	TAXONOMY:						
	NPI:	3	TAXONOMY:						
	NPI:	4	TAXONOMY:						
	NPI:	5	TAXONOMY:						
	NPI:	6	TAXONOMY:						
	NPI:	7	TAXONOMY:						
	NPI:	8	TAXONOMY:						

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID
01 250117062A		

27 TOTAL CHARGE 90.00

28 AMT REC'D INS

29 BALANCE DUE 45.82

30 OWN REF # A1467T133

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131158
REPORT NUMBER CLM3500
ANALYST ID
SIGNON ID
TAXONOMY:
1 2
PROV/XWALK RECIPIENT
ID ID
221904 8718046501
NPI: 1538168968

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15
DOC IND N

CLAIM CONTROL #0905602312004700A
PAGE 36148 ECF 36148 PAGE 1 OF 1
EMC
ORIGINAL CCN:
ADJ CCN:

SFL ZIP: 29817 PRV ZIP: 30023
3 4 5 6 7 8 9
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE
H
----- DIAGNOSIS -----
PRIMARY SECONDARY
438.9 342.90

EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - BETTY

J HORNER

11 DATE OF BIRTH 07/09/1933 12 SEX F

LINE EDITS
01) 510

13 RES 14 ALLOWED LN 15 DATE OF SERVICE 16 PLACE 17 PROC CODE 18 MOD 19 INDIVIDUAL PROV/XWALK 20 CHARGE IND 21 PAY 22 UNITS

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 01/15/08 32 99308 OGV 221904 90.00 1.000
NPI: 1538168968 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER 25 POLICY NUMBER 26 INS CARR PAID

27 TOTAL CHARGE 90.00
28 AMT REC'D INS
29 BALANCE DUE 45.82
30 OWN REF # A1467T525

01 250625240A
02
03

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131159

REPORT NUMBER CLM3500

ANALYST ID

SIGNON ID

TAXONOMY:

1 2
PROV/XWALK RECIPIENT
ID ID

221904 1327080201

NPI: 1538168968

SFL ZIP: 29817

3 4 5
P AUTH TPL INJURY
NUMBER CODE

H

PRV ZIP: 30023

6 7
EMERG PC COORD

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
783.1 707.15

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 20 PRAC SPEC - 15

DOC IND N

CLAIM CONTROL #0905602313004700A

PAGE 36149 ECF 36149 PAGE 1 OF 1

EMC

ORIGINAL CCN:

ADJ CCN:

EDITS

INSURANCE EDITS

01-953

CLAIM EDITS

316

10 RECIPIENT NAME - HELEN

CHAVIS

11 DATE OF BIRTH 01/14/1954

12 SEX F

LINE EDITS

01) 510

13 14 15 16 17 18 19 20 21 22
RES ALLOWED LN DATE OF PLACE PROC MOD INDIVIDUAL CHARGE PAY UNITS
NO SERVICE CODE

23
NDC

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 01/29/08 32 99309 000 221904 130.00 1.000

NPI: 1538168968

TAXONOMY:

2 / / TAXONOMY:

3 / / TAXONOMY:

4 / / TAXONOMY:

5 / / TAXONOMY:

6 / / TAXONOMY:

7 / / TAXONOMY:

8 / / TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID

27 TOTAL CHARGE 130.00

28 AMT REC'D INS

29 BALANCE DUE 71.09

30 OWN REF # A1467T612

01 249984682A

02

03

RESOLUTION DECISION ____

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131160

REPORT NUMBER CLM3500

ANALYST ID

SIGNON ID

TAXONOMY:

1 2
PROV/XWALK RECIPIENT
ID ID
221904 1327080201
NPI: 1538168968

SFL ZIP: 29817

PRV ZIP: 30023

3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE
H

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
787.91 438.9

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 20 PRAC SPEC - 15

DOC IND N

CLAIM CONTROL #0905602314004700A

PAGE 36150 ECF 36150 PAGE 1 OF 1

EMC

ORIGINAL CCN:

ADJ CCN:

EDITS

INSURANCE EDITS

01-953

CLAIM EDITS

316

10 RECIPIENT NAME - HELEN

CHAVIS

11 DATE OF BIRTH 01/14/1954

12 SEX F

LINE EDITS

01) 510

13 RES	14 ALLOWED	15 LN NO	16 DATE OF SERVICE	17 PLACE	18 PROC CODE	19 MOD	20 INDIVIDUAL PROV/XWALK	21 CHARGE IND	22 PAY UNITS
	.00	1	11/20/07	32	99309	000	221904	130.00	1.000
	NPI: 1538168968	2	TAXONOMY:						
	NPI:	3	TAXONOMY:						
	NPI:	4	TAXONOMY:						
	NPI:	5	TAXONOMY:						
	NPI:	6	TAXONOMY:						
	NPI:	7	TAXONOMY:						
	NPI:	8	TAXONOMY:						

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID
01 249984682A		
02		
03		

27 TOTAL CHARGE 130.00

28 AMT REC'D INS

29 BALANCE DUE 73.95

30 OWN REF # A1467T808

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131161
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 20 PRAC SPEC - 15
DOC IND N

CLAIM CONTROL #0905602315004700A
PAGE 36151 ECF 36151 PAGE 1 OF 1

EMC
ORIGINAL CCN:
ADJ CCN:

ANALYST ID
SIGNON ID

TAXONOMY:
1
2
PROV/XWALK RECIPIENT
ID ID
221904 1327080201
NPI: 1538168968

SFL ZIP: 29817
3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE
H

PRV ZIP: 30023

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
401.1 438.9

EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - HELEN

CHAVIS

11 DATE OF BIRTH 01/14/1954 12 SEX F

LINE EDITS
01) 510

13 RES	14 ALLOWED	15 LN NO	16 DATE OF SERVICE	17 PLACE	18 PROC CODE	19 MOD	20 INDIVIDUAL PROV/XWALK	21 CHARGE IND	22 PAY UNITS
	.00	1	12/11/07	32	99308	000	221904	90.00	1.000
	NPI: 1538168968	2	TAXONOMY:						
	NPI:	3	TAXONOMY:						
	NPI:	4	TAXONOMY:						
	NPI:	5	TAXONOMY:						
	NPI:	6	TAXONOMY:						
	NPI:	7	TAXONOMY:						
	NPI:	8	TAXONOMY:						

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24
INS CARR
NUMBER

25
POLICY
NUMBER

26
INS CARR
PAID

01 249984682A
02
03

27 TOTAL CHARGE 90.00
28 AMT REC'D INS
29 BALANCE DUE 50.05
30 OWN REF # A1467T989

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131162
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 20 PRAC SPEC - 15

DOC IND N

CLAIM CONTROL #0905602316004700A
PAGE 36152 ECF 36152 PAGE 1 OF 1

ANALYST ID

SIGNON ID

TAXONOMY:

SFL ZIP: 29817

PRV ZIP: 30023

1 2
PROV/XWALK RECIPIENT
ID ID

3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE

8 9
----- DIAGNOSIS -----
PRIMARY SECONDARY

221904 1327080201
NPI: 1538168968

EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - HELEN

CHAVIS

11 DATE OF BIRTH 01/14/1954

12 SEX F

LINE EDITS

13 14 15 16 17 18 19 20 21 22
RES ALLOWED LN DATE OF SERVICE PLACE PROC CODE MOD INDIVIDUAL CHARGE PAY UNITS
PROV/XWALK IND

23
NDC

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 03/07/08 32 99308 000 221904 90.00 1.000
NPI: 1538168968 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID

27 TOTAL CHARGE 90.00

01 249984682A

28 AMT REC'D INS

02

29 BALANCE DUE 45.82

03

30 OWN REF # A1467T120

RESOLUTION DECISION _____

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131163
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 20 PRAC SPEC - 15
DOC IND N

CLAIM CONTROL #0905602317004700A
PAGE 36153 ECF 36153 PAGE 1 OF 1

ANALYST ID

SIGNON ID

TAXONOMY:

1 2
PROV/XWALK RECIPIENT
ID ID

221904 1023148501

NPI: 1538168968

SFL ZIP: 29817

PRV ZIP: 30023

3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE

H

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
528.2 787.02

EMC
ORIGINAL CCN:
ADJ CCN:

EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - KIMBERLY S CAGLE

11 DATE OF BIRTH 10/25/1957 12 SEX F

13 14 15 16 17 18
RES ALLOWED LN DATE OF SERVICE PLACE PROC CODE MOD

23
NDC

19 20 21 22
INDIVIDUAL CHARGE PAY UNITS
PROV/XWALK IND

LINE EDITS
01) 510

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

.00 1 09/11/07 32 99308 000
NPI: 1538168968 TAXONOMY:

2 / /
NPI: TAXONOMY:

3 / /
NPI: TAXONOMY:

4 / /
NPI: TAXONOMY:

5 / /
NPI: TAXONOMY:

6 / /
NPI: TAXONOMY:

7 / /
NPI: TAXONOMY:

8 / /
NPI: TAXONOMY:

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID

27 TOTAL CHARGE 90.00

28 AMT REC'D INS

29 BALANCE DUE 54.05

30 OWN REF # A1467T119

01 250117062A

02

03

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131164
REPORT NUMBER CLM3500
ANALYST ID
SIGNON ID
TAXONOMY:
1
2
PROV/XWALK RECIPIENT
ID ID
221904 1023148501
NPI: 1538168968

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15
DOC IND N
SFL ZIP: 29817
PRV ZIP: 30023
3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE
H
8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
599.0 458.9

CLAIM CONTROL #0905602318004700A
PAGE 36154 ECF 36154 PAGE 1 OF 1
EMC
ORIGINAL CCN:
ADJ CCN:
EDITS
INSURANCE EDITS
01-953
CLAIM EDITS
316

10 RECIPIENT NAME - KIMBERLY S CAGLE

11 DATE OF BIRTH 10/25/1957 12 SEX F

LINE EDITS
01) 510

13 RES	14 ALLOWED	15 LN NO	16 DATE OF SERVICE	17 PLAGE	18 PROC CODE	19 MOD	20 INDIVIDUAL PROV/XWALK	21 CHARGE IND	22 PAY UNITS	23 NDC
	.00	1	10/04/07	32	99309	000	221904	130.00	1.000	
	NPI: 1538168968	2	TAXONOMY:							
	NPI:	3	TAXONOMY:							
	NPI:	4	TAXONOMY:							
	NPI:	5	TAXONOMY:							
	NPI:	6	TAXONOMY:							
	NPI:	7	TAXONOMY:							
	NPI:	8	TAXONOMY:							
	NPI:		TAXONOMY:							

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24
INS CARR
NUMBER
25
POLICY
NUMBER
26
INS CARR
PAID

01 250117062A

02

03

27 TOTAL CHARGE 130.00

28 AMT REC'D INS

29 BALANCE DUE 79.56

30 OWN REF # A1467T169

RESOLUTION DECISION ____

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131165
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15
DOC IND N

CLAIM CONTROL #0905602319004700A
PAGE 36155 ECF 36155 PAGE 1 OF 1
EMC
ORIGINAL CCN:
ADJ CCN:

ANALYST ID
SIGNON ID
TAXONOMY:

1 2 3 4 5 6 7 8 9
PROV/XWALK RECIPIENT P AUTH TPL INJURY EMERG PC COORD
ID ID NUMBER CODE
221904 1023148501
NPI: 1538168968

PRV ZIP: 30023
----- DIAGNOSIS -----
PRIMARY SECONDARY
599.0

EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - KIMBERLY S CAGLE

11 DATE OF BIRTH 10/25/1957 12 SEX F

LINE EDITS
01) 510

13 14 15 16 17 18 19 20 21 22
RES ALLOWED LN DATE OF SERVICE PLACE PROC CODE MOD INDIVIDUAL CHARGE PAY UNITS
PROV/XWALK IND

.00 1 10/09/07 32 99307 000 221904 39.00 1.000
NPI: 1538168968 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID

01 250117062A
02
03

27 TOTAL CHARGE 39.00
28 AMT REC'D INS
29 BALANCE DUE 17.36
30 OWN REF # A1467T210

RESOLUTION DECISION _____

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131166
REPORT NUMBER CLM3500
ANALYST ID
SIGNON ID
TAXONOMY:
1 2
PROV/XWALK RECIPIENT
ID ID
221904 1023148501
NPI: 1538168968

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15
DOC IND N

CLAIM CONTROL #0905602320004700A
PAGE 36156 ECF 36156 PAGE 1 OF 1
EMC
ORIGINAL CCN:
ADJ CCN:
EDITS
INSURANCE EDITS
01-953

SFL ZIP: 29817 PRV ZIP: 30023
3 4 5 6 7 8 9
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE
H
----- DIAGNOSIS -----
PRIMARY SECONDARY
412. 344.1

CLAIM EDITS
316

10 RECIPIENT NAME - KIMBERLY S CAGLE

11 DATE OF BIRTH 10/25/1957 12 SEX F

13 RES 14 ALLOWED LN 15 DATE OF SERVICE 16 PLACE 17 PROC CODE 18 MOD 19 INDIVIDUAL PROV/XWALK 20 CHARGE IND 21 PAY 22 UNITS
23 NDC

LINE EDITS
01) 510

.00 1 10/30/07 32 99308 000 221904 90.00 1.000
NPI: 1538168968 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER 25 POLICY NUMBER 26 INS CARR PAID

27 TOTAL CHARGE 90.00

01 250117062A

28 AMT REC'D INS

02

29 BALANCE DUE 50.05

03

30 OWN REF # A1467T407

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131167
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15

CLAIM CONTROL #0905602321004700A
PAGE 36157 ECF 36157 PAGE 1 OF 1

ANALYST ID
SIGNON ID

DOC IND N

TAXONOMY:

SFL ZIP: 29853

PRV ZIP: 30023

1
2
PROV/XWALK RECIPIENT
ID ID

3
4
P AUTH TPL INJURY
NUMBER CODE

5
6
EMERG PC COORD

8
9
----- DIAGNOSIS -----
PRIMARY SECONDARY
599.0 782.3

ORIGINAL CCN:
ADJ CCN:

EDITS
INSURANCE EDITS
01-953

221904 1023148501
NPI: 1538168968

CLAIM EDITS
316

10 RECIPIENT NAME - KIMBERLY S CAGLE

11 DATE OF BIRTH 10/25/1957 12 SEX F

LINE EDITS
01) 510

13 RES	14 ALLOWED	15 LN NO	16 DATE OF SERVICE	17 PLACE	18 PROC CODE	19 MOD	20 INDIVIDUAL PROV/XWALK	21 CHARGE IND	22 PAY UNITS
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** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00	1	01/08/08	32	99309	000	221904	130.00	1.000	
NPI: 1538168968	2	TAXONOMY:							
NPI:	3	TAXONOMY:							
NPI:	4	TAXONOMY:							
NPI:	5	TAXONOMY:							
NPI:	6	TAXONOMY:							
NPI:	7	TAXONOMY:							
NPI:	8	TAXONOMY:							

23
NDC

24
INS CARR
NUMBER

25
POLICY
NUMBER

26
INS CARR
PAID

27 TOTAL CHARGE 130.00

01 250117062A

28 AMT REC'D INS

02

29 BALANCE DUE 71.09

03

30 OWN REF # A1467T505

RESOLUTION DECISION _____

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131168
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15

CLAIM CONTROL #0905602322004700A
PAGE 36158 ECF 36158 PAGE 1 OF 1

ANALYST ID
SIGNON ID
TAXONOMY:

1 2
PROV/XWALK RECIPIENT
ID ID
221904 1023148501
NPI: 1538168968

SFL ZIP: 29817 PRV ZIP: 30023
3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE
H

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
401.1 344.1

EMC
ORIGINAL CCN:
ADJ CCN:
EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - KIMBERLY S CAGLE

11 DATE OF BIRTH 10/25/1957 12 SEX F

LINE EDITS
01) 510

13 RES	14 ALLOWED	15 LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	19 INDIVIDUAL PROV/XWALK	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	09/04/07	31	99306	000	221904	175.00		1.000
	NPI: 1538168968	2	TAXONOMY:							
	NPI:	3	TAXONOMY:							
	NPI:	4	TAXONOMY:							
	NPI:	5	TAXONOMY:							
	NPI:	6	TAXONOMY:							
	NPI:	7	TAXONOMY:							
	NPI:	8	TAXONOMY:							
	NPI:		TAXONOMY:							

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER
25 POLICY NUMBER
26 INS CARR PAID

27 TOTAL CHARGE 175.00
28 AMT REC'D INS
29 BALANCE DUE 106.85
30 OWN REF # A1467T539

01 250117062A
02
03

RESOLUTION DECISION _____

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131169
REPORT NUMBER CLM3500
ANALYST ID
SIGNON ID

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15
DOC IND N

CLAIM CONTROL #0905602323004700A
PAGE 36159 ECF 36159 PAGE 1 OF 1
EMC
ORIGINAL CCN:
ADJ CCN:

TAXONOMY: 1 2 3 4 5 6 7 8 9
PROV/XWALK RECIPIENT P AUTH TPL INJURY EMERG PC COORD ---- DIAGNOSIS ----
ID ID NUMBER CODE PRIMARY SECONDARY
221904 1023148501
NPI: 1538168968 H 595.0

EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - KIMBERLY S CAGLE

11 DATE OF BIRTH 10/25/1957 12 SEX F

LINE EDITS
01) 510

13 RES	14 ALLOWED	15 LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	19 INDIVIDUAL PROV/XWALK	20 CHARGE IND	21 PAY	22 UNITS	
	.00	1	01/22/08	32	99307	000	221904	39.00		1.000	*****
	NPI: 1538168968		TAXONOMY:								** AGENCY USE ONLY **
	NPI:	2	/ /								** APPROVED EDITS **
	NPI:	3	/ /								** REJECTED LINE EDITS **
	NPI:	4	/ /								**
	NPI:	5	/ /								*****
	NPI:	6	/ /								!!!!!!!!!!!!!!!!!!!!!!!!!!!!
	NPI:	7	/ /								! CLAIMS/LINE PAYMENT INFO !
	NPI:	8	/ /								! EDIT PAYMENT DATE !
	NPI:		/ /								!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER
25 POLICY NUMBER
26 INS CARR PAID

27 TOTAL CHARGE 39.00

01 250117062A

28 AMT REC'D INS

02

29 BALANCE DUE 10.26

03

30 OWN REF # A1467T577

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131170
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15
DOC IND N

CLAIM CONTROL #0905602324004700A
PAGE 36160 ECF 36160 PAGE 1 OF 1

ANALYST ID
SIGNON ID
TAXONOMY:

1 2
PROV/XWALK RECIPIENT
ID ID
221904 1023148501
NPI: 1538168968

SFL ZIP: 29817

PRV ZIP: 30023

3 4 5
P AUTH TPL INJURY
NUMBER CODE
H

6 7
EMERG PC COORD

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
453.8 564.00

EMC
ORIGINAL CCN:
ADJ CCN:

EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - KIMBERLY S CAGLE

11 DATE OF BIRTH 10/25/1957 12 SEX F

LINE EDITS
01) 510

13 14 15 16 17 18 19 20 21 22
RES ALLOWED LN DATE OF PLACE PROC MOD INDIVIDUAL CHARGE PAY UNITS
NO SERVICE CODE PROV/XWALK IND

23
NDC

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 12/04/07 32 99308 000 221904 90.00 1.000
NPI: 1538168968 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID

01 250117062A

02

03

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

27 TOTAL CHARGE 90.00
28 AMT REC'D INS
29 BALANCE DUE 50.05
30 OWN REF # A1467T972

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131171

REPORT NUMBER CLM3500

ANALYST ID

SIGNON ID

TAXONOMY:

1 2
PROV/XWALK RECIPIENT
ID ID
221904 1023148501
NPI: 1538168968

SFL ZIP: 29817

PRV ZIP: 30023

3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE

H

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
466.0 242.90

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 20 PRAC SPEC - 15

DOC IND N

CLAIM CONTROL #0905602325004700A

PAGE 36161 ECF 36161 PAGE 1 OF 1

EMC

ORIGINAL CCN:

ADJ CCN:

EDITS

INSURANCE EDITS

01-953

CLAIM EDITS

316

10 RECIPIENT NAME - KIMBERLY S CAGLE

11 DATE OF BIRTH 10/25/1957 12 SEX F

LINE EDITS

01) 510

13 14 15 16 17 18 19 20 21 22
RES ALLOWED LN DATE OF PLAGE PROC MOD INDIVIDUAL CHARGE PAY UNITS
NO SERVICE CODE PROV/XWALK IND

23
NDC

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 02/14/08 32 99308 000 221904 90.00 1.000

NPI: 1538168968

TAXONOMY:

2
NPI: TAXONOMY:

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NPI: TAXONOMY:

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NPI: TAXONOMY:

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NPI: TAXONOMY:

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NPI: TAXONOMY:

7
NPI: TAXONOMY:

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NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
!
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID

27 TOTAL CHARGE 90.00

01 250117062A

28 AMT REC'D INS

02

29 BALANCE DUE 45.82

03

30 OWN REF # A1467T109

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131172
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15
DOC IND N

CLAIM CONTROL #0905602326004700A
PAGE 36162 ECF 36162 PAGE 1 OF 1
EMC
ORIGINAL CCN:
ADJ CCN:

ANALYST ID
SIGNON ID
TAXONOMY:

SFL ZIP: 29817

PRV ZIP: 30023

1
2
PROV/XWALK RECIPIENT
ID ID
221904 8718046501
NPI: 1538168968

3
4
P AUTH TPL INJURY
NUMBER CODE
H

5
6
EMERG PC COORD

8
9
----- DIAGNOSIS -----
PRIMARY SECONDARY
787.01 434.91

EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - BETTY

J HORNER

11 DATE OF BIRTH 07/09/1933 12 SEX F

LINE EDITS
01) 510

13 RES	14 ALLOWED	15 LN NO	16 DATE OF SERVICE	17 PLACE	18 PROC CODE	19 MOD	20 INDIVIDUAL PROV/XWALK	21 CHARGE IND	22 PAY UNITS
	.00	1	02/14/08	32	99308	OGV	221904	90.00	1.000

NPI: 1538168968 TAXONOMY:

NPI: 2 TAXONOMY:

NPI: 3 TAXONOMY:

NPI: 4 TAXONOMY:

NPI: 5 TAXONOMY:

NPI: 6 TAXONOMY:

NPI: 7 TAXONOMY:

NPI: 8 TAXONOMY:

24
INS CARR
NUMBER

25
POLICY
NUMBER

26
INS CARR
PAID

27 TOTAL CHARGE 90.00

28 AMT REC'D INS

29 BALANCE DUE 45.82

30 OWN REF # A1467T109

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

01 250625240A

02

03

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131173
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15

CLAIM CONTROL #0905602327004700A
PAGE 36163 ECF 36163 PAGE 1 OF 1

ANALYST ID
SIGNON ID

DOC IND N

TAXONOMY:
1 2
PROV/XWALK RECIPIENT
ID ID
221904 8718046501
NPI: 1538168968

SFL ZIP: 29817 PRV ZIP: 30023
3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE
H

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
434.91 331.0

ORIGINAL CCN:
ADJ CCN:
EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - BETTY J HORNER

11 DATE OF BIRTH 07/09/1933 12 SEX F

LINE EDITS
01) 510

13 RES	14 ALLOWED	15 LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	19 INDIVIDUAL PROV/XWALK	20 CHARGE IND	21 PAY	22 UNITS
--------	------------	----------	--------------------	----------	--------------	--------	--------------------------	---------------	--------	----------

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00	1	12/04/07	32	99309	OGV	221904	130.00	1.000
NPI: 1538168968	2	TAXONOMY:						
NPI:	3	TAXONOMY:						
NPI:	4	TAXONOMY:						
NPI:	5	TAXONOMY:						
NPI:	6	TAXONOMY:						
NPI:	7	TAXONOMY:						
NPI:	8	TAXONOMY:						

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID
--------------------	------------------	------------------

27 TOTAL CHARGE 130.00

01 250625240A

28 AMT REC'D INS

02

29 BALANCE DUE 79.56

03

30 OWN REF # A1467T976

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131174

REPORT NUMBER CLM3500

ANALYST ID

SIGNON ID

TAXONOMY:

1 2
PROV/XWALK RECIPIENT
ID ID
221904 8718046501
NPI: 1538168968

SFL ZIP: 29817

PRV ZIP: 30023

3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE
H

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 20 PRAC SPEC - 15

DOC IND N

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
707.03 707.06

CLAIM CONTROL #0905602328004700A

PAGE 36164 ECF 36164 PAGE 1 OF 1

EMC

ORIGINAL CCN:

ADJ CCN:

EDITS

INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - BETTY

J HORNER

11 DATE OF BIRTH 07/09/1933

12 SEX F

LINE EDITS
01) 510

13 14 15 16 17 18 19 20 21 22
RES ALLOWED LN DATE OF SERVICE PLACE PROC CODE MOD INDIVIDUAL CHARGE PAY UNITS
PROV/XWALK IND

23
NDC

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1
NPI: 1538168968

10/30/07

32

99309

OGV

221904

130.00

1.000

TAXONOMY:

2 / TAXONOMY:

3 / TAXONOMY:

4 / TAXONOMY:

5 / TAXONOMY:

6 / TAXONOMY:

7 / TAXONOMY:

8 / TAXONOMY:

NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
!
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 25
INS CARR POLICY
NUMBER NUMBER

26
INS CARR
PAID

27 TOTAL CHARGE 130.00

28 AMT REC'D INS

29 BALANCE DUE 79.56

30 OWN REF # A1467T405

01 250625240A

02

03

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131175
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15

CLAIM CONTROL #0905602329004700A
PAGE 36165 ECF 36165 PAGE 1 OF 1

ANALYST ID
SIGNON ID

TAXONOMY:
1 2
PROV/XWALK RECIPIENT
ID ID
221904 6727505601
NPI: 1538168968

SFL ZIP: 29817 PRV ZIP: 30023
3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE
H

8 9
----- DIAGNOSIS -----
PRIMARY SECONDARY
401.1 600.00

ORIGINAL CCN:
ADJ CCN:
EDITS
INSURANCE EDITS

CLAIM EDITS
316 950

LINE EDITS
01) 510

10 RECIPIENT NAME -

11 DATE OF BIRTH / / 12 SEX

13 RES	14 ALLOWED	15 LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	19 INDIVIDUAL PROV/XWALK	20 CHARGE IND	21 PAY	22 UNITS
--------	------------	----------	--------------------	----------	--------------	--------	--------------------------	---------------	--------	----------

	.00	1	10/09/07	32	99308	OGV	221904	90.00	1.000	
NPI:	1538168968	2	TAXONOMY:							
NPI:		3	TAXONOMY:							
NPI:		4	TAXONOMY:							
NPI:		5	TAXONOMY:							
NPI:		6	TAXONOMY:							
NPI:		7	TAXONOMY:							
NPI:		8	TAXONOMY:							

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID
--------------------	------------------	------------------

01 251127368C1
02
03

27 TOTAL CHARGE	90.00
28 AMT REC'D INS	
29 BALANCE DUE	54.05
30 OWN REF #	A1467T248

RESOLUTION DECISION _____

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

INSURANCE POLICY INFORMATION

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131176

REPORT NUMBER CLM3500

ANALYST ID

SIGNON ID

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 20 PRAC SPEC - 15

DOC IND N

CLAIM CONTROL #0905602330004700A

PAGE 36166 ECF 36166 PAGE 1 OF 1

EMC

ORIGINAL CCN:

ADJ CCN:

TAXONOMY:

SFL ZIP: 29817

PRV ZIP: 30023

1 2

PROV/XWALK RECIPIENT

3 4

P AUTH TPL INJURY

6 7

EMERG PC COORD

8 9

----- DIAGNOSIS -----

PRIMARY SECONDARY

466.0

EDITS

INSURANCE EDITS

01-953

CLAIM EDITS

316

10 RECIPIENT NAME - RAYMOND

JOLLEY

11 DATE OF BIRTH 04/11/1934

12 SEX M

LINE EDITS

01) 510

13	14	15	16	17	18	19	20	21	22
RES	ALLOWED	LN	DATE OF	PLACE	PROC	INDIVIDUAL	CHARGE	PAY	UNITS
		NO	SERVICE		CODE	PROV/XWALK	IND		

23
NDC

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 10/16/07 32 99307 OGV 221904 39.00 1.000

NPI: 1538168968

TAXONOMY:

NPI: 2

/ / TAXONOMY:

NPI: 3

/ / TAXONOMY:

NPI: 4

/ / TAXONOMY:

NPI: 5

/ / TAXONOMY:

NPI: 6

/ / TAXONOMY:

NPI: 7

/ / TAXONOMY:

NPI: 8

/ / TAXONOMY:

NPI: 8

/ / TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24
INS CARR
NUMBER

25
POLICY
NUMBER

26
INS CARR
PAID

27 TOTAL CHARGE 39.00

28 AMT REC'D INS

29 BALANCE DUE 17.36

30 OWN REF # A1467T290

01 251127368C1

02

03

RESOLUTION DECISION ____

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"

* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131177
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15
DOC IND N

CLAIM CONTROL #0905602331004700A
PAGE 36167 ECF 36167 PAGE 1 OF 1
EMC

ANALYST ID
SIGNON ID
TAXONOMY:

1 2
PROV/XWALK RECIPIENT
ID ID
221904 6727805601
NPI: 1538168968

SFL ZIP: 29817 PRV ZIP: 30023
3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE
H

8 9
----- DIAGNOSIS -----
PRIMARY SECONDARY
401.1 600.00

ORIGINAL CCN:
ADJ CCN:
EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - RAYMOND

JOLLEY

11 DATE OF BIRTH 04/11/1934 12 SEX M

13 14 15 16 17 18
RES ALLOWED LN DATE OF SERVICE PLACE PROC CODE MOD
23
NDC

.00 1 09/11/07 31 99306 OGV 221904 175.00 1.000
NPI: 1538168968 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID

01 251127368C1

02

03

27 TOTAL CHARGE 175.00
28 AMT REC'D INS
29 BALANCE DUE 106.85
30 OWN REF # A1467T106

RESOLUTION DECISION ____

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

LINE EDITS
01) 510

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

RUN DATE 03/10/2009 000131178
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15
DOC IND N

CLAIM CONTROL #0905602332004700A
PAGE 36168 ECF 36168 PAGE 1 OF 1
EMC
ORIGINAL CCN:
ADJ CCN:

ANALYST ID
SIGNON ID

TAXONOMY:
1 2
PROV/XWALK RECIPIENT
ID ID
221904 6727805601
NPI: 1538168968

SFL ZIP: 29817 PRV ZIP: 30023
3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE
H

8 9
----- DIAGNOSIS -----
PRIMARY SECONDARY
401.1 600.00

EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - RAYMOND

JOLLEY

11 DATE OF BIRTH 04/11/1934 12 SEX M

13 14 15 16 17 18 19 20 21 22
RES ALLOWED LN DATE OF SERVICE PLACE PROC MOD INDIVIDUAL CHARGE PAY UNITS
CODE CODE

23
NDC

LINE EDITS

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 03/01/08 32 99308 OGV 221904 90.00 1.000
NPI: 1538168968 TAXONOMY:
2 / / TAXONOMY:
3 / / TAXONOMY:
4 / / TAXONOMY:
5 / / TAXONOMY:
6 / / TAXONOMY:
7 / / TAXONOMY:
8 / / TAXONOMY:
NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID

01 251127368C1

02

03

27 TOTAL CHARGE 90.00

28 AMT REC'D INS

29 BALANCE DUE 45.82

30 OWN REF # A1467T117

RESOLUTION DECISION ____

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131179
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15
DOC IND N

CLAIM CONTROL #0905602333004700A
PAGE 36169 ECF 36169 PAGE 1 OF 1
EMC

ANALYST ID
SIGNON ID

TAXONOMY:
1 2
PROV/XWALK RECIPIENT
ID ID
221904 6727805601
NPI: 1538168968

SFL ZIP: 29817 PRV ZIP: 30023
3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE
H

8 9
DIAGNOSIS
PRIMARY SECONDARY
600.00 331.0

ORIGINAL CCN:
ADJ CCN:
EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - RAYMOND

JOLLEY

11 DATE OF BIRTH 04/11/1934 12 SEX M

LINE EDITS
01) 510

13 14 15 16 17 18 19 20 21 22
RES ALLOWED LN DATE OF SERVICE PLACE PROC CODE MOD INDIVIDUAL CHARGE PAY UNITS
PROV/XWALK IND

23
NDC

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 12/17/07 32 99308 OGV 221904 90.00 1.000
NPI: 1538168968 TAXONOMY:
2 / / TAXONOMY:
3 / / TAXONOMY:
4 / / TAXONOMY:
5 / / TAXONOMY:
6 / / TAXONOMY:
7 / / TAXONOMY:
8 / / TAXONOMY:
NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID

27 TOTAL CHARGE 90.00
28 AMT REC'D INS
29 BALANCE DUE 54.05
30 OWN REF # A1467T101

01 251127368C1

02

03

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131180
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15

CLAIM CONTROL #0905602334004700A
PAGE 36170 ECF 36170 PAGE 1 OF 1

ANALYST ID
SIGNON ID

TAXONOMY:
1 2
PROV/XWALK RECIPIENT
ID ID
221904 3780103693
NPI: 1538168968

SFL ZIP: 29853 PRV ZIP: 30023
3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE
H

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
458.9 453.8

EMC
ORIGINAL CCN:
ADJ CCN:
EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - NEVA

J DARBY

11 DATE OF BIRTH 11/15/1930 12 SEX F

LINE EDITS
01) 510

13 RES 14 ALLOWED LN 15 DATE OF SERVICE 16 PLACE 17 PROC CODE 18 MOD 19 INDIVIDUAL PROV/XWALK 20 CHARGE IND 21 PAY 22 UNITS

23
NDC

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 09/13/07 32 99308 OGV 221904 90.00 1.000
NPI: 1538168968 TAXONOMY:
2 / / TAXONOMY:
3 / / TAXONOMY:
4 / / TAXONOMY:
5 / / TAXONOMY:
6 / / TAXONOMY:
7 / / TAXONOMY:
8 / / TAXONOMY:
NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER 25 POLICY NUMBER 26 INS CARR PAID

01 248340993B

02

03

27 TOTAL CHARGE 90.00
28 AMT REC'D INS
29 BALANCE DUE 54.05
30 OWN REF # A1467T204

RESOLUTION DECISION _____

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131181
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15
DOC IND N

CLAIM CONTROL #0905602335004700A
PAGE 36171 ECF 36171 PAGE 1 OF 1
EMC
ORIGINAL CCN:
ADJ CCN:

ANALYST ID
SIGNON ID
TAXONOMY:

SFL ZIP: 29817

PRV ZIP: 30023

1 2
PROV/XWALK RECIPIENT
ID ID
221904 1327080201
NPI: 1538168968

3 4 5
P AUTH TPL INJURY
NUMBER CODE
H

6 7
EMERG PC COORD

8 9
----- DIAGNOSIS -----
PRIMARY SECONDARY
599.0 428.0

EDITS
INSURANCE EDITS
01-953

CLAIM EDITS
316

10 RECIPIENT NAME - HELEN

CHAVIS

11 DATE OF BIRTH 01/14/1954 12 SEX F

LINE EDITS
01) 510

13 14 15 16 17 18 19 20 21 22
RES ALLOWED LN DATE OF PLACE PROC INDIVIDUAL CHARGE PAY UNITS
NO SERVICE CODE MOD PROV/XWALK IND

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 09/18/07 31 99306 OGV 221904 175.00 1.000
NPI: 1538168968 TAXONOMY:
2 / / TAXONOMY:
3 / / TAXONOMY:
4 / / TAXONOMY:
5 / / TAXONOMY:
6 / / TAXONOMY:
7 / / TAXONOMY:
8 / / TAXONOMY:
NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID

27 TOTAL CHARGE 175.00
28 AMT REC'D INS
29 BALANCE DUE 106.85
30 OWN REF # A1467T129

01 249984682A
02
03

RESOLUTION DECISION ____

ADDITIONAL DIAG CODES:

INSURANCE POLICY INFORMATION

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131182
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15
DOC IND N

CLAIM CONTROL #0905602336004700A
PAGE 36172 ECF 36172 PAGE 1 OF 1
EMC
ORIGINAL CCN:
ADJ CCN:

ANALYST ID
SIGNON ID

TAXONOMY:
1 2
PROV/XWALK RECIPIENT
ID ID
221904 7716446701
NPI: 1538168968

SFL ZIP: 29817 PRV ZIP: 30023
3 4 5 6 7
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE

8 9
----- DIAGNOSIS -----
PRIMARY SECONDARY
716.96 682.6

EDITS
INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 510

10 RECIPIENT NAME - MARY

WALKER

11 DATE OF BIRTH 09/17/1944 12 SEX F

13 RES 14 ALLOWED LN 15 DATE OF SERVICE 16 PLACE 17 PROC CODE 18 MOD 19 INDIVIDUAL CHARGE 20 PAY UNITS 21 22
PROV/XWALK IND

23
NDC

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 01/01/08 32 99308 000 221904 90.00 1.000
NPI: 1538168968 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
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NPI: TAXONOMY:
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NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER 25 POLICY NUMBER 26 INS CARR PAID

27 TOTAL CHARGE 90.00
28 AMT REC'D INS .00
29 BALANCE DUE 90.00
30 OWN REF # A1467T435

01

02

03

RESOLUTION DECISION

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131183
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15
DOC IND N

CLAIM CONTROL #0905602337004700A
PAGE 36173 ECF 36173 PAGE 1 OF 1
EMC
ORIGINAL CCN:
ADJ CCN:

ANALYST ID
SIGNON ID
TAXONOMY:

SFL ZIP: 29817

PRV ZIP: 30023

1 2
PROV/XWALK RECIPIENT
ID ID
221904 7716446701
NPI: 1538168968

3 4 5
P AUTH TPL INJURY
NUMBER CODE

6 7
EMERG PC COORD

8 9
----- DIAGNOSIS -----
PRIMARY SECONDARY
428.0 578.9

EDITS
INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 510

10 RECIPIENT NAME - MARY

WALKER

11 DATE OF BIRTH 09/17/1944 12 SEX F

13 14 15 16 17 18 19 20 21 22
RES ALLOWED LN DATE OF SERVICE PLACE PROC CODE INDIVIDUAL CHARGE PAY UNITS
PROV/XWALK IND

23
NDC

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 02/07/08 32 99308 000 221904 90.00 1.000
NPI: 1538168968 TAXONOMY:
2 / / TAXONOMY:
3 / / TAXONOMY:
4 / / TAXONOMY:
5 / / TAXONOMY:
6 / / TAXONOMY:
7 / / TAXONOMY:
8 / / TAXONOMY:
NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID

27 TOTAL CHARGE 90.00
28 AMT REC'D INS .00
29 BALANCE DUE 90.00
30 OWN REF # A1467T107

01
02
03

RESOLUTION DECISION _____

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/10/2009 000131184
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM

CLAIM CONTROL #0905602337004700A
PAGE 36173 ECF 36173 PAGE 1 OF 1

PROVIDER ID.
1538168968

000134207
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE
03/06/2009

PAGE
1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
A1467T535	0904011671026600A 01		011508	99308	90.00 90.00	0.00 0.00	R R	1780486166	L DANIELS EDITS: L01 510	000	L01 953	0.00	0.00
	TOTALS		1		90.00	0.00						0.00	0.00

FOR AN EXPLANATION OF THE
ERROR CODES LISTED ON THIS
FORM REFER TO: "MEDICAID
PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS
PHONE THE D.H.H.S. NUMBER
SPECIFIED FOR INQUIRY OF
CLAIMS IN THAT MANUAL.

CERT. PG TOT

CERTIFIED AMT

\$0.00

MEDICAID PG TOT

MEDICAID TOTAL

CHECK TOTAL

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

CHECK NUMBER

PROVIDER NAME AND ADDRESS

SHREEDHAR M MAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA SC 29202

1538168968

000134208
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE

03/06/2009

PAGÈ

2

[illegible]DEBIT BALANCE
PRIOR TO THIS
REMITTANCE

75.70

**YOUR CURRENT
DEBIT BALANCE**

75.70

MEDICAID TOTAL

0.00

ADJUSTMENTS

-75.70

CHECK TOTAL

0.00

CERTIFIED AMT

0.00

0.00

CHECK NUMBER

**TO BE REFUNDED
IN THE FUTURE**

0.001

PROVIDER NAME AND ADDRESS

SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202

RUN DATE 03/03/2009 000134209
REPORT NUMBER CLM3500
ANALYST ID WEND
SIGNON ID WLSN

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 15
DOC IND Y

CLAIM CONTROL #0904011671026600A
PAGE 34538 ECF 34538 PAGE 1 OF 1
EMC
ORIGINAL CCN:
ADJ CCN:

TAXONOMY: SFL ZIP: 29817 PRV ZIP: 30023
1 2 3 4 5 6 7 8 9
PROV/XWALK RECIPIENT P AUTH TPL INJURY EMERG PC COORD ---- DIAGNOSIS ----
ID ID NUMBER CODE PRIMARY SECONDARY
221904 1780486166
NPI: 1538168968
477.9 879.8

EDITS
INSURANCE EDITS
01-953

CLAIM EDITS

LINE EDITS
01) 510

10 RECIPIENT NAME - LEVITICUS DANIELS

11 DATE OF BIRTH 02/06/1926 12 SEX M

13 RES 14 ALLOWED LN 15 DATE OF SERVICE 16 PLACE 17 PROC CODE 18 MOD 19 INDIVIDUAL PROV/XWALK 20 CHARGE IND 21 PAY 22 UNITS
23
NDC

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 01/15/08 32 99308 000 221904 90.00 1.000
NPI: 1538168968 TAXONOMY:
2 / / TAXONOMY:
3 / / TAXONOMY:
4 / / TAXONOMY:
5 / / TAXONOMY:
6 / / TAXONOMY:
7 / / TAXONOMY:
8 / / TAXONOMY:
NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER 25 POLICY NUMBER 26 INS CARR PAID

27 TOTAL CHARGE 90.00
28 AMT REC'D INS .00
29 BALANCE DUE 90.00
30 OWN REF # A1467T535

01 250461684A
02
03

RESOLUTION DECISION _R_

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
SHREEDHAR M NAGNUR
DOCTOR'S CARE PA
PO BOX 100193
COLUMBIA

SC 29202-3193

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RJN DATE 03/03/2009 000134210
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM

CLAIM CONTROL #0904011671026600A
PAGE 34538 ECF 34538 PAGE 1 OF 1



State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

March 31, 2009

Ms. Karen G. Hardy
Billing Manager
Doctors Care
4416 Forest Drive
Columbia, South Carolina 29206

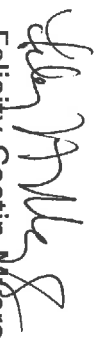
Dear Ms. Hardy:

We have received your request to stop delivery of Error Correction Forms (ECF's) and remittances that are intended for Dr. Shreedhar M. Nagnur to your facility.

We researched and found that Dr. Nagnur's address on his individual NPI number had not been changed from your facility address to his new address. This change has been made and you should no longer receive Dr. Nagnur's ECF's and remittances.

We apologize for any inconvenience this may have caused you. Thank you for your continued support and participation in the South Carolina Medicaid program.

Sincerely,


Felicity Costin-Myers
Deputy Director

FCM/rst

Log # 522